UNIVERSITY OF GONDAR

COLLEGE OF MEDICINE AND HEALTH SCIENCES

SCHOOL OF PUBLIC HEALTH

ASSESSMENT OF PERCEIVED BARRIERS TO BEHAVIORAL CHANGE TOWARDS THE PREVENTION OF HIV/AIDS AMONG URBAN COMMUNITY OFGONDAR TOWN, NORTH GONDAR ADMINISTRATIVE ZONE, ANRS, NORTH WEST ETHIOPIA.

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Acronyms

AAC- Anti Aids Club
AIDS - Acquired Immunodeficiency Syndrome
ANRS- Amhara National Regional State
BCC - Behavioral Change Communication
CBO - Community –Based Organization
CDC - Centers for Disease Control
CSW- Commercial Sex Workers
DHS- Demographic and Health Survey
FHI - Family Health International
HBM - Health Belief Model
HIV - Human Immunodeficiency Virus
ICN - International Council for Nurses
IEC - Information, Education, Communication
KAP - Knowledge, Attitude, Practice
MOH - Ministry of Health
NGO - Non-Governmental Organization
PHRD - Policy and Human Resource Development
PWHA - People with HIV/AIDS
SSA - Sub - Saharan Africa
STI - Sexually Transmitted Infection
UNAIDS - Joint United Nations Program on HIV/AIDS
UOG- University of Gondar
USA - United States of America
VCT - Voluntary Counseling and Testing
WHO - World Health Organization

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Abstract

Background

Globally, HIV/AIDS has created an enormous challenge to the survival of mankind. It has now become the leading cause of death in many developing countries especially in the Sub-Saharan African countries. Ethiopia is one of the seriously affected countries by the problem. The disease is affecting the majority of the population, particularly the productive age group between 15-49 years, resulting in social and economic crisis.

Objective: To assess perceived barriers to behavioral change towards the prevention of HIV/AIDS among the urban population in Gondar Town.

Methods: A community based crossectional and qualitative study was conducted in Gondar town from June 20-July 4,2011. Eight hundered eleven (811) individuals were interviewed. Multistage sampling with systematic and simple random sampling and indepth-interveiw were the techniques used.

Result: Half, (49.1%) of the respondants mentioned condom as mode of preventive but only 36% of the respondants reported utilization. Unmarried individuals had utilized condoms 2.775 times more than married ones (adjusted OR=2.775, 95% C.I 1.788-4.307). Illitrates had unfavorable attitude than litrate, (Adjusted OR=0.483, 95% C.I 0.241-0.968). The qualitative study showed that majority of the interviwees expressed that there was high unsafe sexual practices. Having more than one sexual partner, unprotected sex and early commencement of sexual practice is still very high among the urban population.

Conclusion: There was still a discrepancy between knowledge about HIV/AIDS and behavioral change towards the prevention of the disease. The major perceived barriers were illegal video houses, khat houses and unemployement.

Recommendations: Planners and implementers need to strengthen the current IEC strategy in a view of adapting better behavioral change.

Policy maker and community at large make stronger legislative actions directed to control illegal video showing and khat houses and focus creation of job opportunity.

1. INTRODUCTION

1.1 Statement of the problem

Previously unknown human immunodeficiency virus (HIV) is a lethal pathogen that has now infected millions of people throughout the world. Acquired immunodeficiency syndrome (AIDS) has responded poorly to the conventional medical and public health approaches in part, because of the complexity and unique features of the retrovirus (1). The disease has now become the leading cause of death in this world creating negative impacts on health, education, agriculture, industry and all other walks of life (2).

Since its recognition in the early 1980s till the end of 2010, over 42 million people were living with the virus out of which more than 70% were in the sub-Saharan Africa (SSA). Over 90% of the infection occurs in the developing world (3).

HIV/AIDS is now a growing public health concern with complex social and behavioral issues related to control, prevention of the transmission and care of patients by medical personnel. The social stigma associated with HIV/AIDS, the disease's long period of invisibility and the determination of whether the infection is related to behavioral risks such as sexual transmission or occupational exposure add to the complexity of HIV/AIDS in many countries especially the Sub-Saharan Africa (4).The developed world achieved significant results in the prevention and control of the disease mainly via the behavioral change interventions while the developing countries haven't yet achieved (5).

Therefore, HIV/AIDS has a direct linkage to life style and behavior, an understanding of the extent of knowledge, attitudes, beliefs and practice of the population about HIV/AIDS assume significance in monitoring and evaluating impacts of HIV/AIDS and developing effective strategies for HIV/AIDS prevention and control programs in the near future (6). My hypothesis is, do socio-demographic factors associated with Knowledge, attitud and practice, ultemately affect behavioral changet in related to HIV/AIDS.

1. 2. LITERATURE REVIEW

1.2.1. KAP related to HIV/AIDS

Acquired immune- deficiency syndrome is an illness characterized , according to Centers for Disease Control criteria ,as the presence of antibody to HIV and a T4 cell less than 200 /µl of blood , or the presence of HIV and certain opportunistic infections including diseases that affect both the body and brain (2).

The major modes of transmission are sexual, parental and prenatal. Studies have revealed that the best way to protect against HIV infection is sexual abstinence, followed by mutual monogamous sexual relationship (7) ,The mutual monogamy with known sero-negative partner is the best and the most effective way to avoid risk of HIV transmission (8). The third alternative preventive method is use of condom when the above two preventive methods are impractical (3).

The key to preventing HIV /AIDS is to stop the transmission of HIV virus before it enters the human body (4). The prevention of AIDS appears simple. But, unfortunately, the task is not at all simple. Disseminating HIV/AIDS knowledge is different from changing HIV attitudes and intention, which is different again from changing behavior that put one at risk for HIV/AIDS (9).

As many researchers have discovered with a number of diseases prevention practices, people generally are resistant to change their attitudes and behavior, even though the means of disease prevention is clear and effective, perhaps people do not understand the risk and the way to prevent it. Research has shown, however, that when people clearly understand a health risk and means of prevention, they still are resistant to change. Additional research has demonstrated that even in cases, where people understand the risk, accepted the preventive method, and reported that they wanted to and would change, subsequent behavior didn’t always change (10).

On the other hand, studies have indicated that a new behavior is most likely to be generally adopted if the categories of people, called opinion leaders adopt it.

The difficulty with the behavior change needed for HIV/AIDS prevention is that they often consist of intimate behaviors which people are reluctant to endorse (11). Changing sexual behavior is not an easy task. And in high prevalence areas, there is a feeling that most sexually active adults with any risk behavior are already infected. As the result , attention is now turning increasingly towards young people who are not yet sexually active or who are just active (12). Because of long period of time between HIV infection and clinical signs of AIDS, risky behaviors are not easily perceived as associated with HIV infection, making the change in behavior a difficult undertaking. The understanding of HIV and related behaviors is clearly far from complete, especially in the youngest age groups where there is most evidence for change (13).

The central concern of IEC is bringing about good health behavior. Positive changes in health behavior are ultimate aims of IEC programs. If behaviors change but health is not subsequently improved, the result is a paradox that must be resolved by examining other issues (14). It is important to know about how particular media can help achieve good behaviors related to HIV/AIDS. Each medium has its own advantages and disadvantages, so that each may be suited to particular circumstances. For example, researches have shown that mass media can raise awareness of specific facts, because the mass media are assumed to carry a certain authority and reliability. Mass media can also model behaviors and positive attitudes in a person of respected members of the target community. Later on in the process, however, target populations appear less interested in media authority and they are in opinions and behaviors of people to whom they feel close. Interpersonal communication becomes primary, while the mass media play a supporting role (15).

Experience has shown that tracking behavior is an essential for strengthening prevention and control programs. Moreover, the behavior data serve as early warning systems for HIV/AIDS. Tracking behavior improves program evaluation, and any change in behavioral data can help explain variation in the disease prevalence (16).
An important step in the modification of health behavior is motivating an individual to want to change the behavior. When an individual has insight into his own motivation then it is easier to bring about positive behavioral change. Attitude–change approaches

to changing behavior implicitly assume that if people can be persuaded that the current health behaviors are poor, they will be motivated to change those health habits. Studies have also demonstrated that it is far preferable to keep people from developing problematic behaviors than to try to help them stop behaviors once they are already in place (17).

There are models and frameworks used in HIV/AIDS prevention that are derived from social psychology and concepts of communication (18). The most highly influential and widely researched theory of why people practice health behavior is the health belief model .This model states that whether or not a person practices a particular health behavior can be understood by knowing two factors: the degree to which the person perceives a personal health threat and the perception that a particular health practice will be effective in reducing that threat (10).

According to this model, sufficient knowledge of the disease is essential but not the only prerequisite to behavioral change. The model explains that socio-demographic factors such as education, age, sex, race, ethnicity and socio-economic status are believed to influence behavior indirectly by affecting perceived threat, outcome expectation and self- efficacy. The perceived barrier is most powerful, and single predictor of HBM dimensions in all studies related to health behaviors. The major factor that contributes to the lack of effective prevention against HIV/AIDS is the absence of an appropriate method for identifying people who are at risk and determining factors that should be modified (19). The HBM assists in understanding why many young people frequently engaged in unsafe sexual practices. For instance, the perceived drawbacks of condom use (embarrassment and lack of pleasure) are salient and come quickly to mind. The perceived benefits are harder to visualize (10).

Because of long period of time between HIV infection and clinical signs of AIDS, risky behaviors are not easily perceived as associated with HIV infection, making the change in behavior a difficult undertaking. The understanding of HIV and related behaviors is clearly far from complete, especially in the youngest age groups where there is most evidence for change (20).

1. 2.2. Behavioral change towards the prevention of HIV/AIDS

Attitudes about gender also affect people's ability to be in control of sex. Some practical approaches and activities that can help people practice safer sex include building people's knowledge and skills , so that they feel more confident to discuss about safer sex , addressing social and community barriers that make it difficult for people to have safer sex (11).

A study conducted in Africa has indicated that poverty was the primary cause of spread of HIV/AIDS in Africa which when combined with poor governance and lack of clear political commitment, inadequate health infrastructure, and high illiteracy levels were major causes for the disaster (12).

In order to reduce the gap between knowledge and behavioral change towards the prevention of HIV/AIDS, intensive, extensive and sustainable IEC activities through all possible media, materials and methods, taking into account the five contextual domains of HIV/AIDS prevention framework should be planned, tested, implemented and evaluated to bring about a significant behavioral changes among the population (13).

Generally, in order to bring about positive behavioral change, a well-implemented HIV/AIDS prevention and control strategy should target the behavior to reduce risk and vulnerability by delaying the first sex, increasing condom use, reducing the number of sexual partners, promoting access to voluntary counseling Testing (VCT) and reducing other forms of compromising behaviors such as excessive alcohol consumption, khat chewing, cigarette smoking and drug abuse.

1.2.3 Barriers to behavioral change towards the prevention of HIV/AIDS

The most difficult area of HIV/AIDS prevention lies in the areas of behavior change. Behavioral change is certainly difficult to inspire and extremely hard to measure. Furthermore, the theoretical basis for the behavior has been difficult to characterize .For instance, despite the efforts made by national government and NGOS. South African populations have been slow to adopt safer sex practices. The reasons for the lack of the success in changing sexual behavior are complex, but some of the contributing factors include culture, gender and the high prevalence of violence (3).

There are many factors that influence the practice of health behavior related to HIV/AIDS including social, emotional , cognitive factors , perceived symptoms and factors related to access to health services. Health behavior differs reliably by demographic variables. One study has shown that health behaviors especially those related to HIV/AIDS are commonly practiced by more affluent, better educated people under low level of stress and those with available social support. It was indicated that individuals who are low in socio–economic status, who are females and who do not have convenient health services are less likely to use health services generally do not practice health behavior that require health related interventions (4).

Giving people information about HIV/AIDS and the risks of unsafe sexual practices is indispensable. But even when we know the risks of unsafe sex, it can often be difficult to stop it. Some barriers that stop people from practicing safe sex come from the wider environment; for instance, social and economic inequalities between sexual partners can make people hard to have safe sexual practices .The social and economic inequalities also lead to lack of access to sexual health, information and services including condoms. Negative cultural or religious ideas about sex and sexuality, and laws that stop people from getting the information and services they need, can make safer sex difficult. Attitudes about gender also affect people's ability to be in control of sex. Some practical approaches and activities that can help people practice safer sex include building people's knowledge and skills , so that they feel more confident to discuss about safer sex , addressing social and community barriers that make it difficult for people to have safer sex (5).

Studies have demonstrated that the IEC intervention regarding HIV/AIDS has achieved most of its objectives in upgrading the individuals' knowledge of HIV prevention, with some changes in attitude but the behavioral change observed as the result of IEC interventions is low, in many African countries. Another study in India has shown that, the knowledge of HIV/AIDS was found to be almost non-existent among respondents in urban slums of India, especially among women. The study has found out that the illiteracy, linked with poverty, created a gap in knowledge about HIV/AIDS (6).

On the other hand, poverty and substance abuse lead some people to increased risks of HIV infection. Inequalities in job opportunities leave women dependon men for economic needs, which can place them at the mercy of sexually irresponsible or physically abusive men. Coercion is not only the factor causing poor women to have unsafe sex for their emotional gratifications, but to preserve the relationship and their own self - esteem, minority of women frequently choose unsafe sex. In Uganda, for instance, sexual mores, gender stratifications and gender role-stereotypes operate powerfully to discourage men and women from practicing safer sex (20). Bahirdar study has also revealed that urban populations of low socio-economic status in bahirdar were found to be particularly vulnerable to HIV as result of their low social status (30).

A study done in Uganda has found out that the spread of HIV/AIDS is mostly via sexual intercourse and largely influenced by behavior and attitudes. As it was revealed by the study, changes of behavior and attitude are significantly related to age, sex, education, ethnic group and number of patients' deaths known to respondents. Moreover, the study has demonstrated that more educated respondents had experienced significantly more changes in attitudes and behavior than the less educated. In addition, the better educated tended to be more explicit in stating reasons for changes taking place, which is consistent with other studies showing that the educated people to be better informed about HIV/AIDS and thus more likely to have more tolerant attitude towards AIDS patients .It was also shown by the study that over 70% of the respondents, all of whom were aware of the AIDS epidemics, were willing to go for HIV testing to know their sero-status. This bold decision signifies a major change of attitude towards the prevention of HIV/AIDS (20).

1.3. Justification of the study

About 91% of the infection in Ethiopia occurs among young adults aged 15-49 years. Given that this range encompasses the most economically productive segment of the population, the highest number cases in this broad age group adversely affect labor productivity and hence economic development of the country. The age range also represents the period of life when investments in education are just beginning to pay off. Bringing about positive behavioral change through preventive efforts is currently the only effective way to check the spread of HIV in the majority of the population.

Many community-based studies in Ethiopia have indicated that there is still a gap between knowledge and behavioral changes towards the prevention of HIV/AIDS. Very few studies have attempted to examine the barriers to change of behavior towards the prevention of HIV/AIDS among the urban population in Ethiopia.

Therefore, this study was conducted in response to this need and to assess perceived barriers to behavioral change the prevention of HIV/AIDS among the urban community in Gondar. The findings of the study can be utilized as baseline information for further studies related to behavioral change interventions.

2. OBJECTIVES OF THE STUDY

2.1 General Objective

- Assessment of perceived barriers to behavioral change towards the prevention of HIV/AIDS among the urban population in Gondar Town.

2. 2 Specific Objectives

A. To assess knowledge pertaining to HIV prevention.

B. To explore attitudes pertaining to HIV prevention,

C. To findout practices pertaining to HIV prevention.

D.To identify perceived barriers to behavioral change towards the prevention of HIV/AIDS

3. Methods

3. 1 Study Design

The study design was Community based cross- sectional study triangulated by qualitative method

3.2 Study area and period

The study was conducted in Gondar town from June 20 –July 4/ 2011. Gondar town is found in North Gondar Administrative zone of Amhara National Regional state and is 750 km North West of Addis. According to the 2007 Ethiopian census report, Gondar has a total population of 206, 987 and more than half (108,902) of them are females. Administratively the town is divided into 12 administrative Keble's. The Prevalence of HIV/AIDS in Amhara region is 2.8. Have two referral hospital and seven health centers including the three newly established health centers. Among these health institutions one referral hospital and the two health centers have been offering anti retroviral therapy and follow up care for HIV positive patients.

3. 3 .Source and Study Population

All individuals residing in Gondar town were the source population. The study subjects were 811 urban populations aged 15-49 years living in Gondar town.

3.3.1 Inclusion Criteria

Those adults residing in the study sites for more than 6 months during the data collection.

3.3.2 Exclusion criteria

All adults who are unable to hear, mentally disabled and seriously ill.

3.4. Sample size and Sampling procedure

. Sample size

The sample size was determined considering proportion of Knowledge= 0.8 Attitude=0.4, Practice=0.4 (according to EDHS 2005) to be within 5% marginal error and 95% confidence interval of certainty (alpha =0.05). Based on this assumption, the actual sample size for the study was computed using one

sample population proportion formula as indicated below.The three proportions were calculated and the highest value was taken.

$$n = \frac{Z^2\alpha/2 \; p(1-p)}{d^2}$$

Where, n = Sample size

Zα/2 = Critical value =1.96

d = Precision (marginal error) =0.05

P = k=0.8, (1.96)2. (.8x.2)/0.0025=**245.86**

Proportion of attitude=0.4 and p=0.4%.

$$n = \frac{(1.96)\ 2\ (.4 \times .6)}{(0.05)\ 2} = \mathbf{368.64}$$.

The design effect is 2, and adding 10% non-response rate,

368.64x2= 737.28+10%= 737.28+73.728 =**811** study subjects.

- **Sampling procedure for the quantiitative study**

Multi-stage sampling technique was used. From all the 21 kebeles, six were selected by random sampling technique. Individual Keble households were selected using a systematic sampling technique and the number of households were determined using proportionate-to-population size. One individual in the selected household was selected randomly and interviewed (annex 2). For household with more than one individual, only one person was selected using lottery method. If the selected HH was closed during data collection, it was revisited three times in different time intervals and when interviewers failed to get an individual in the HH, it was excluded from the survey. When the person in the specified age group from the selected household is not available during the data collection the next nearest HH was included in the survey.

- **Sampling procedure for qualitative study**

This study used selected subjects representing Gondar town .The respondents were approached through kebele administrations. Inclusion criteria for respondents were age 15-49, identified by kebele manager as informative and able to provide rich and in-depth responses. The study subjects included those with positive HIV and without in equal proportion.All agred to participate the

interview. The criteria of sample size were to achive saturation in the qualitative data, from all respondents interviewed, in order to verify that no new information was found in addition to achiving saturation.

3.5. Variables

Dependent Variables

- Knowledge, attitude and practices related to HIV prevention

Independent Variables

- ✓ Socio-demographic characteristics - sex, age, religion, ethnicity, marital status, educational status, occupation, income, access to radio and television.
- ✓ Sources of information related to HIV/AIDS

3.6. Operational definitions of key terminologies

- **Perceived barriers** – factors considered by the individuals to be obstacles to the prevention of HIV/AIDS.
- **Knowledge**- Individuals' understanding related to transmission and prevention of HIV/AIDS.
- **Attitude** – Individuals' predisposition to respond in a favorable or an unfavorable manner towards the prevention of HIV/AIDS.
- **Practice**- an overt behavior or habit of an individual towards or against the prevention of HIV/AIDS..
- **Behavioral change** – gaining knowledge, developing favorable attitude and practicing prevention method of HIV/AIDS.
- **Compressive Knowledge about means of prevention of HIV/AIDS-** Subjects were considered knowledgeable, if they correctly identified the three major methods HIV prevention, namely, abstinence, being faithful to one partner and proper use of condom and rejecting the two most common local misconceptions.
- **Drug** –Substances that brought about addiction.

3.7. DATA COLLECTION Procedure

3.7.1 Quantitative data

Ten data collectors who completed grade 12 and speak Amharic were recruited. Two supervisors {Bsc.Nurse} were selected. The main responsibility of the supervisors was checking whether the questionnaire was correctly and consistently completed or not. The enumerators and the supervisors were given training for one day on procedures, techniques and ways of collecting the data by the main investigator. The data were collected from the selected households,using the structured questionnaire. The questionnaire was developed in English and translated into Amharic and then back to English to check for its consistency. Prior to the actual data collection, the Amharic version questionnaire was pre-tested on 5% (40) of the respondents in the same age group of the study subjects in a kebele not included in the main survey. The questionnaire was tested for clarity, acceptability, flow, repetition and time required in interviewing one respondent. Based on the pre-testing, minor modifications of questions, wordings, phrases and time required to interview a respondent were made.

Before the commencement of the actual data collection, discussions were held with Gondar city Mayor and Kebele Leaders in order to obtain necessary information and supports. The data collection was completed within fifteen days. Before starting the interview respondents were briefed about the purpose of the study by enumerators after getting their informed consents. The principal investigator coordinated all administrative and logistic conditions. Moreover, informed and supportive supervisions were made throughout the data collection processes by the principal investigator and the supervisors.

3.7.2 Qualitative data

Qualitative data were collected using face-to face in-depth interviews by the main investigator and one male interviewer.The interview guide was informed by the main investigator. Before each in-depth interview oral informed concent was obtained, reviewing the study pourpose and addressing any concerns respondents had about confidentiality.Interviews lasted about 30 minutes and were carried out according to the

protocol designed by the principal investigator.Each in-depth interview was audiotaped and noted by hand writing.

Data Quality Control

To assure the quality of the data, properly designed data collection instrument was developed. Training was given for data collectors and supervisors. Every day, the collected data was reviewed and checked for completeness and consistency by supervisors and the principal investigator. Pre-testing and supervisions were made before and during actual data collection respectively.

3.8. Data Processing and Analysis for quantitative study

The collected data from each respondent was entered and analyzed using the EPInfo version 6 and SPSS version16 computer software packages. Data cleaning was carried out, and frequency distributions and cross tabulations were made for each of the variables. Odds ratios were computed to assess the strength of the associations. Bivariate and multivariate analyses were also employed and p-value less than 0.05 were taken. Binary logistic regression was used to see the effect of each independent variable on the dependent variables.

Data Analysis for qualitative study

Audiotapes of the interviews were transcribed verbatim in Amharic, qualitative data analysis involved one researcher reading the transcribed interviews to develop themes and a code book that captured the textual thems guided by the in-depth interview guide. Interviews were then coded by the researcher.

4. Ethical Consideration

Ethical clearance was obtained from the Ethical Committee of University of Gondar. A formal letter was written to all concerned authorities and permission was secured at all levels. Informed verbal consent was obtained from each respondent, after the purpose of the study was explained to him/her. Anonymity and confidentiality of the information was assured and privacy of each respondent was honored throughout the data collection process. Important principles in HIV/AIDS work include compassion, solidarity, confidentiality, consent, responsibility and tolerance. Practices should support equity and distributive justice.

5. RESULTS

5.1. Socio-demographic characteristics

A total of 811 urban populations aged 15-49 years were included in the study.The overall response rate was 100%.The results of the quantitative and the qualitative survey are presented as follows.

The socio-demographic variables of the sample population are summarized in Table 1. Majority of study subjects 472 (58.2%) were females. Most of the respondents 326 (40.2%) were in the age group of 25-34 years.The mean age was 29.06 with a SD of ±8 years, with minimum and maximum value 15 and 49 years, respectively. Majority of the study subjects, 565 (69.6 %) were followers of Orthodox religion. The majority were Amhara ethnic group, 662 (81.6%). Most of the respondents 364 (44.9%) were not married at all.

Regarding the educational status, Majority of the study subjects were attended high schools 341 (42.0%). Most of the study subjects were students, 166 (20.5%), Pertaining to the economic status of most of the study subjects, 309 (38.1%) earned less than 500 .00 Ethiopia birr per month. A considerable number of respondents, 364 (44.9%) could not identify their household income. Majority of the study subjects, 637 (78.5%) had radio while, 548 (67.6%) had television at the household level.

Table 1. Socio- demographic characteristics of the respondents, Gondar Town, August, 2011.

Variables	Frequency (n =811)	Percent
Sex		
Female	472	58.2
Male	339	41.8
Age (years)		
15-24	247	30.5
25-34	326	40.2
35-49	238	29.2
Religion		
Orthodox	565	69.6
Muslims	150	18.5
Catholic	52	6.4
Protestants	37	4.6
No religion	7	0 .9
Ethnicity		
Amhara	662	81.6
Tigre	99	12.2
Agew	24	3.0
Others	26	3.2
Marital status		
Single	364	44.9
Married	270	33.3
Divorce	90	11.1
Separeted	35	4.3
Widowed	52	6.4
Education		
Illiterate	96	11.8
Read and write	108	13.3
Grade 1-6	163	20.1
Grade 7-12	341	42.0
12+	103	12.7

Occupation		
Students	166	20.5
House wife	150	18.5
Trader	134	16.5
Private employee	123	15.2
Civil servant	100	12.3
Daily worker	100	12.3
Commercial Sex worker	36	4.4
Others	2	0.2
Monthly income		
<500 Birr	309	38.1
500-999 Birr	85	10.5
>1000 Birr	53	6.5
Do not know	364	44.9
Radio in the HH		
Yes	637	78.5
No	174	21.5
Television in the HH		
Yes	548	67.6
No	263	32.4

5.2. Knowledge related to HIV /AIDS.

Majority 748 (92.2%) of the respondents indicated that unprotected sex was the main mode of transmission and 713 (87.9%) mentioned abstinance as a very good means of prevention. Misconceptions related to HIV/AIDS were still present. One-hundered three (12.7%) had at least one misconception of HIV transmission. Misconceptions mainly mentioned by low socio-economic groups and parents of PLWHA. Allmost half, 398 (49.1%) of the study subjects had comprehessive knowledge. Majority, 672 (82.8%) of the study subjects said that information they obtained had improved their practices.

Table 2.Knowledge of the respondents, related to HIV/AIDS, Gondar Town, August, 2011.

Variable	Frequency (n=811)	Percent
Knowledge of modes of transmission of HIV/AIDS*		
Unprotected sex	748	92.2
Infected instruments	584	72
Unsafe blood transfusions	395	48.7
MTCT	305	37.6
Three major modes of transmission	190	23.4

Knowledge of preventive methods of HIV/AIDS*		
Abstinence	713	87.9
Being faithful to one partner	515	63.5
Correct and consistent use of condom	398	49.1
Three major methods of prevention	398	49.1
*- Total exceeds 100% due to multiple responses		
Misconceptions about transmission of HIV infection		
Mosquito's bites	103	12.7
Eating eggs of a hen swallowed used condom	88	10.8
Using the same toilet	51	6.2
Shaking hands	34	4.2
Eating with PWHA	26	3.2
Living with PWHA	21	2.6
At least two misconception	90	11.1
Rejecting at least two misconceptions	398	49.1
Compressive Knowledge about HIV/AIDS (n=811)		
Yes	398	49.1
No	413	50.9
The information you obtain about HIV/AIDS improve your practice (n=811)		
Yes	672	82.9
No	139	17.1

5.3. Attitudes related to HIV /AIDS

Majority 715 (88.2%) responded that they knew people who were infected with HIV or died of AIDS, of those 385 (53.8%) rated great change. About 664 (81.9%) had perceived that healthy looking person could be infected with HIV/AIDS.Some 327 (40.3%) of the subjects rated that chance of contracting HIV/AIDS with one unprotected sex was very high.

Table 3. Attitudes of the respondents, related to HIV/AIDS, Gondar Town, August, 2011.

Variable	Frequency	Percent
Do you know people who are infected with HIV or died of ADIS? (n=811)		
Yes	715	88.2
No	96	11.8
If yes How you rate positive behavioral change, (n=715)		
Great change	385	53.8
Some change	205	28.7
No change	106	14.8
Others	19	2.7
Healthy looking person can be infected with HIV.(n=811)		
Yes	664	81.9
No	147	18.1
Chance of contracting HIV with one unprotected sex (n=811)		
Very high	327	40.3
Very low	96	11.8
Medium	175	21.6
I do not think I will contract HIV	190	23.4
Others	23	2.8
Changed previous attitude (n=811)		
Yes	665	81.9
No	146	18

5.4. Practices related to HIV/AIDS

Majority, 609 (75%) of the respodents had practiced sex. Among 609 (75%) of the respondents, 36 (5.9%) had started sex of the age of 10-14 years. In addition, 531 (87.2%) of the subjects were practicing sex in the past one year. From those 144 (27.1%) had more than one partener. The mean (±SD) and median ages of the respondents were 23.5±1.61 and 20, ranging from 10 to 39 years. Most, 531 (87.2%) of the subjects had practiced sex in the past one year, from which 191 (36%) used condom and the rest 340 (64%) did not use.From those used condom, 68 (35.6%) of the subjects used condom everytime. The main reason for not using condom during sexual intercourse was attributed to have trust in the partner 101 (29.7%).

Table 4. Practice of the respondents, related to HIV/AIDS, , Gondar Town, August, 2011.

Variable	Frequency(n=811)	Percent
Practiced sex (n=811)		
Yes	609	75.1
No	202	24.9
Age sex started (n=609)		
10-14 years	36	5.9
15-19 years	277	45.5
20-24 years	198	32.5
25-29 years	64	10.5
30-34 years	8	1.3
35-39 years	3	0.5
Do not know	23	3.7
Sexual practices in the past one year (n=609)		
Yes	531	87.2
No	78	12.8
Number of sexual partner in the past one year (n=531)		
1 partener	387	72.9
>1 partener	144	27.1
Condom utilization in the past one year (n=531)		
Yes	191	36
No	340	64
What frequency use condoms? (n=191)		
Everytime	68	35.6
Sometimes	61	31.9
Rarely	62	32.5
Reasons for not using condoms (n=340)		
Trust in partner	101	29.7
Do not like	61	17.9
Religious disapproval	60	17.6
Partner objected	50	14.7
Not available	31	9.1
Stigma	19	5.6
Too expensive	18	5.4

5.5. Knowledge, attitude and practice related to VCT

Most of the respondents, 719 (88.6%) heard about VCT, of those 691 (96.1%) had favorable attitude to VCT, among those who had favorable attitude to VCT, 467 (67.6%) had undergone VCT and 224 (32.4%) did not. The main reason for not undergoing VCT was fear of positive results, 120 (53.5%).

Table 5. Knowledge, attitude and practice related to VCT, Gondar Town, August, 2011.

Variable	Frequancy	Percent
Heard about VCT (n=811)		
Yes	719	88.6
No	92	11.3
What is your attitude towards the VCT service (n=719)		
Good	691	96.1
Bad	13	1.8
Do not know	15	2.1
If your response is good, undergone VCT (n=691)		
Yes	467	67.6
No	224	32.4
Reasons for not undergoing VCT (n=224)		
Fear of positive results	120	53.5
Fear of stigma and discrimination	79	35.3
Service is inaccessible	11	4.9
Cost is high	8	3.6
Do not know	6	2.7

5.6. Identified perceived barriers to behavioral change towards HIV prevention and recommendation to overcome barriers.

About 565 (69.7%) of the study subjects reported that unsafe sexual behavior was high, of those 414 (51%), and 345 (42.5%) mentioned illegal video houses and unemployement as perceived barriers to behavioral change toward HIV/ADIS prevention respectively. Finally almost half of the study subjects recommended; strengthen school health education, strengthen IEC activities and empowerment of women to overcome barriers.

Table 6. Perceived barriers to behavioral change and recommendation to overcome barriers, Gondar Town, August, 2011.

Variable	Number	Percent
Unsafe sexual behavior in urban community (n=811)		
Increased	565	69.7
Decereased	246	30.3
Percived barriers to behavioral change* (n=811)		
Increased illegal video houses	414	51.0
Unemployement	345	42.5
Traditional Malpractice	254	31.3
Lack of recreation	246	30.3
Low community involvement	244	30
Low IEC	234	28.8
Stigma and discrimination	211	26
Low religious involvement	117	14.4
Inequalities	116	14.3
Recommended to overcome barriers to behavioral change* (n=811)		
Strengthen school health education	443	54.6
Strengthen the IECactivities	432	53.3
Women empowerment	427	52.7
Legal measure on illegal video houses	426	52.5
Increased community involvement	416	51.3
Remove stigma and discrimination	391	48.2
Increased involvement of the religios organization	346	42.7

*- Total exceeds 100% due to multiple responses

5.6.1 Behavior related substance abuse in the past one year

One hundered- eighty (22.2%) of the respondents had been chewing khat during their lifetime, 164 (20.2%) had been drinking alcohol, 129 (15.9%) were smoking cigarette and 17 (2.1%) had been using drug.On the other hand, 170 (21%) were chewing chat regularly in the last tewelve months,150 (18.5%) were drinking alcohol, 107 (13.2%) were smoking cigarate regularily and 14 (1.7%) were taking drug regularly.

5.7. Sources of information, Preference of settings and means of Communication to increase knowledge related to HIV/AIDS

Majority 736 (90.8%) had heared about HIV/AIDS through radio, of those, 293 (39.8%) had heared at least once a week. About 689 (85%) watched about HIV/AIDS on television, from those, 249 (36.1%) wacthed at least once a week. While, 492 (60.7%) of the subject read about HIV/AIDS in printed materials. Most 642 (79%) got information about HIV/AIDS in the last twelve months, of which, 289 (45%) got information about mode of transmission.

About 336 (41.4%) and 317 (39.1%) of the respondents mentioned health institution and radio as sources of information respectively. Most of the respondents, 563 (69.4%) preferred health institutions for adoption of positive behavioral change. Most of the study subjects, 497 (61.3%) preferred group discussions best method of transferring information related to HIV/AIDS in order to bring about behavioral changes.

Table 7. Sources of information, Preference of settings and means of communication related to HIV/AIDS, Gondar Town, August, 2011.

Variable	Frequency	Percent
Ever heard radio (n=811)		
Yes	736	90.8
No	75	9.2
How often listend (n=736)		
At least once a week	293	39.8
At least once in two weeks	177	24
At least once in three weeks	136	18.5
At least once in four weeks	130	17.6

Ever watched television (n=811)		
Yes	689	85
No	122	15
Howoften watched (n=689)		
.At least once a week	249	36.1
At once in two weeks	182	26.4
At once in three weeks	100	14.5
At once in four weeks	158	22.9
During the last four months, have read any printed materials related to HIV/AIDS		
Yes	492	60.7
No	319	39.3
Learned about HIV/AIDS the last 12 months (n=811)		
Yes	642	79.1
No	169	20.9
What learned? (n=642)		
Transsmission	289	45
Prevention	211	32.8
Impacts	142	22.1
Sources helped to increase the knowledge*		
Health professionals	336	41.4
Radio	317	39.1
Peers	296	36.5
Television	282	34.8
Family	227	30
Printed materials	220	27.1
Religious leaders	191	23.5
AACs	187	23
PLWHA	180	22.2
Teacher	149	18.4
Preference of settings to obtain information*		
Health institutions	563	69.4
Community -based organizations	277	34.1
Religious institutions	268	33
Schools	265	32.6
Home	237	29.2
Preference of means of communication*		
Discussions	497	61.3
Songs	350	43.2
Dramas	325	40.1
News	292	36
Speeches	274	33.8

*- Total exceeds 100% due to multiple responses

5.8. Logistic Regression showing the relation of Socio- demographic Variables and sexual practices.

The socio- demographic variables were compared with sexual practice as summarized in Table 8. Among the socio-demographic variables age, marital status, education and income was significantly associated with sexual practice.The age group of 15-34 were less likely to practice sex than 35-49 (AOR=0.136, 95% CI 0.055-0.333).The unmarried individuals were less likely to practice sex than the married individuals (AOR =0.043, 95% CI 0.021-0.888).

Illitrate had 4.355 times more sexual practice than litrate (AOR =4.355, 95% CI 1.507-12.589). Employed had 2.323 times more sexual practice than unemployed (AOR =2.323,95% CI 1.093-4.938). Those with low income less than five hundered birr per month had 4.241 times more sexual practice than those with monthly income greater than or equal to five-hundered birr (AOR =4.241, 95% CI 2.534-7.099). The other socio –demographic variables did not show significant association with sexual practices under binary logistic regression.

Table 8 .Logistic Regression showing the relation of socio-demographic variables and sexual practice, Gondar Town , August, 2011.

Variables	Sexual practice		COR (95% CI)	AOR (95% CI)	P-value
	n=811				
	Yes=609	No=202			
Sex					
Male	237	102		1	
Female	372	100	0.625 (0.453-0.860)	0 .847 (0.544-1.320)	
Age group					
15-34	383	190		1	
35-49	226	12	**0.107(0.058-0.196)**	**0.136(0.055-0.333)***	**0.000**
Religion					
Christian	486	168		1	
Non-christian	123	34	0.800 (0.526-1.215)	1.099 (0.610-1.978)	
Ethnicity					
Amhara	483	179		1	
Non-Amhara	126	23	0.493 (0.306-0.793)	0.455 (0.234-0.885)	

Marital status					
Single	185	179		1	
Married	260	10	**0.040 (.020-.077)**	**0 .043 (0. 021-0.088)***	**0.000**
Education					
Illiterate	86	10		1	
Literate	523	192	**3.157 (1.607-6.203)**	**4.355 (1.507-12.589)***	**0.001**
Occupation					
Employed	88	12		1	
Unemployed	521	190	**2.674 (1.431-4. 999)**	**2.323 (1.093-4.938)***	**0.002**
Income					
<500 Birr	268	41		1	
≥ 500 Birr	341	161	**3.086 (2.114-4.505)**	**4.241 (2.534-7.099)***	**0.000**
Has radio					
Yes	472	165		1	
No	137	37	0.773 (0.516-1.157)	0.573 (0.317-1.035)	
Has television					
Yes	406	142		1	
No	203	60	0.845 (0.598-1.194)	1.040 (0.626 -1. 729)	

***-**Significantly associated

5.9. Logistic Regression showing the relation of socio–demographic variables and changed previous attitude.

The socio- demographic variables were compared with changed previous attitude as summarized in Table 9. Among the socio-demographic variables, religion, education, radio, and television were statistically associated with changed previous attitude. Christians had 2.277 times more favorable attitude than non Christians. (AOR= 2.277, 95% C.I 1.350 -3.843). Illitrates had unfavorable attitude than litrate, (AOR=0.483, 95% C.I 0.241-0.968).

Those who have radio had 1.765 times more favorable attitude than those who have not, (AOR=1.765, 95% C.I 1.006-3.097). Those who have television had 2.079 times more favorable attitude than those who have not, (AOR=2.079, 95% C.I 1.274-3.392). The other socio –demographic variables did not show significant association with changed previous attitude under binary logistic regression

Table 9. Logistic Regression showing the relation of socio-demographic variables and changed previous attitude, Gondar Town, August, 2011.

Variables	Changed attitude		COR (95% CI)	AOR (95% CI)	P-value
	n=811				
	Yes=665	No=146			
Sex					
Male	282	57		1	
Female	383	89	1.150(0.797-1.658)	0.982(0.620-1.555)	
Age group					
15-34	466	107		1	
35-49	199	39	0.854(0.571-1.276)	0.772(0.437-1.365)	
Religion					
Chrisitian	549	105		1	
Non-Christian	116	41	**1.848(1.223-2.792)**	**2.277(1.350-3.843)***	**0.005**
Ethinicity					
Amhara	546	116		1	
Non-Amhara	119	30	1.187(0.758-1.857)	0.642(0.324-1.272)	
Marital status					
Single	308	56		1	
Married	229	41	0.985(0.636-1.525)	1.173(0.720-1.910	
Education					
Illitrate	68	28		1	
Litrate	597	118	**0.480(0.296-0.778)**	**0.483(0.241-0.968)***	**0.004**
Occupation					
Employed	89	11		1	
Unemployed	576	135	1.896(0.986-3.646)	1.657(0,721-3.811)	
Income					
<500	250	59		1	
≥500	415	87	0.888(0.616-1.281)	0.787(0.489-1.265)	
Radio					
Yes	541	96		1	
No	124	50	**2.272 (1.533-3.368)**	**1.765 (1.006-3.097)***	**0.000**
Television					
Yes	473	75		1	
No	192	71	**2.332 (1.618-3.361)**	**2.079(1.274-3.392)***	**0.000**

* **Significantly associated**

5.10. Logistic Regression showing the relation of socio-demographic variables and male condom utilization in the past one year.

The socio- demographic variables were compared with male condom utilization as summarized in Table 10. Among the socio-demographic variables, sex, religion, marital status, and occupation were statistically associated with condom utilization. It was shown that, males to use male condom themselves 1.626 times more than the female persuad to use male condoms (AOR= 1.626, 95% C.I 1.051-2.517).

Moreover, Christian individuals utilized condoms about 3.254 times more than the non-Christian individuals, (AOR=3.254, 95% C.I 1.731-6.115). In addition, unmarried individuals had utilizing condoms 2.775 than those married ones, (AOR=2.775, 95% C.I 1.788-4.307). Employed individuals had utilizing condoms 1.941 than those unemployed individuals, (AOR=1.941, 95% C.I 1.088-3.464). Other socio –demographic variables did not show any significant association with condom utilization under binary logistic regression.

Table 10. Logistic Regression showing the relation of socio-demographic variables and male condom utilization in the past one year,Gondar Town, August, 2011.

Variables	Use Male condom n=531		COR (95% CI)	AOR (95% CI)	P-value
	Y =191	N=340			
Sex					
Male	89	126		1	
Female	102	214	**1.482(1.034-2.123)**	**1.626(1.051-2.517)***	**0.4**
Age group					
15-34	126	206		1	
35-49	65	134	1.261(.871-1.826)	1.323(0.815-2.149)	
Religion					
Christian	166	256		1	
Non-Christian	25	84	**2.179(1.338- 3.547)**	**3.254(1.731-6.115)***	**0.002**
Ethnicity					
Amhara	142	280		1	
Non-Amhara	49	60	**0 .621(0.405-0.953)**	**0.509(0.289-0.893)***	**0.037**
Marital status					
Single	78	83		1	
Married	62	189	**2.865(1.879-4.367)**	**2.775(1.788-4.307)***	**0.000**
Educational status					
Illiterate	24	45		1	
Literate	167	295	0.942(0.554-1.601)	1.383(0.688-2.780)	
Occupation					
Employed	36	45		1	
Unemployed	155	295	**1.523(.943-2.459)**	**1.941(1.088-3.464)***	**0.109**
Monthly income					
<500 Birr	81	144		1	
≥500 Birr	110	196	1.002(0.700-1.435)	0 .996(0.625-1.597)	
Has radio					
Yes	152	271		1	
No	39	69	0.992(0.639-1.541)	1,059(0.590-1.900)	
Has television					
Yes	124	242		1	
No	67	98	0.749(0.513-1.094)	1.161(0.686-1.964)	

***-Significantly associated

RESULTS OF THE QUALITATIVE FINDING

Socio-demographics

Total of 30 respondents (19 female,11 male) were interviwed between June 20 and July 4, 2011. The respondents were 15 - 49 years old. Majority 17 were 25-35 years old, 8 were 15-25 and 5 were >35 years old. Of all the interviwees, 18 were unmarried, 10 were married and 2 were divorced. Among all respondents 20 were grade 7-12, 5 could read and write, 3 were grade 1-6 and 2 were above grade 12. Majority 13 were students, 8 were merchants, 6 were housewives, 2 were daily labourers and one was government employee.

1) Means of transmission and prevention of HIV/AIDS

All had some dgree of perception about means of transmission and prevention of HIV/AIDS. Twenty seven of the respondents said that HIV/AIDS could be transmited through unsafe sexual intercourse, 19 of the respondents said that HIV/AIDS could be transmited through sharing sharp materials, 2 of the interviewees identified that HIV/AIDS could be transmited by unscreened blood transfusion, 6 of the respondents described that HIV/AIDS could be transmited from mother to child and 8 of the informants expressed that HIV/AIDS could be transmited by traditional mal-practices.

Twenty three of the respondents explained that, HIV/AIDS could be prevented by abstinance, 10 of the interviewees told that HIV/AIDS could be prevented using condom, 6 of the informants said that HIV/AIDS could be prevented by being faithful.

In addition, 2 of the interviewees explained that, HIV/AIDS could be prevented by carefull use of sharp materials.

2) Barriers to behavioral change related to HIV/AIDS prevention

Majority, 19 of the interviwees expressed that there was high unsafe sexual practices. Having more than one sexual partner, unprotected sex and early commencement of sexual practice is still very high among the population due to increase in illegal video and chat houses, alcohol drinking, unemployement, inadequate recreational facilities and traditional malpractice. Two of the respondents said that there was medium

behavioral change toward HIV/ADIS prevention, Six of the participants said that, there was low behavioral change toward HIV/ADIS prevention and 3 of the informants explained that they had no idea about behavioral change toward HIV/ADIS prevention.

3) Impacts of socio- demographic factors on behavioral change

Most 19 of the respondents said that sex had impact on behavioral change, 17 of the participants explained that,age had impact on behavioral change,14 of the respondents said that, dwelling area had impact on behavioral change, 3 of the interviwees expressed that educational status had impact on behavioral change, one, two, and one of the respondents expressed that migration to urban,marital status and religion had impact on behavioral change respectively. In addition, 9 and 1 of the respondents voiced that unemployment and illegal video houses had impact on behavioral change respectively.

4) Important sources of information for behavioral change

Majority 22 and 17 of the respondents said that television and radio were very good source of information for behavioral change respectively, 4 of the participants told that newspaper,pamplates and magazines were important source of information for behavioral change, 2 of the informants explained that religious father and schools were good source of information for behavioral change. Finally one of the respondents expressed that health institutions, friends and families were good source of information for behavioral change.

5) Impacts of IEC on behavior related to HIV prevention

Nine of the participants said that IEC brought good behavioral change toward HIV/ADIS prevention, 17 of the informants voiced that IEC brought very good behavioral change toward HIV/ADIS prevention and the rest 4 of the interviwees indicated that IEC brought excellent behavioral change toward HIV/ADIS prevention.

6) Suggestions by indepth interviewees

6.1) Socio economic suggestions

Socio-economic conditions should be paid great attention such as creation of job opportunities especially for the youths, discouraging harmful traditional practices like early marriage, tonsillectomy, tooth extraction and tattooing and improving care of HIV patients both at health institutions and home level. It is also very important to empowering women and raise community participationto bring about positive behavioral change.

6.2) IEC

They had also suggested that IEC activities should be highly promoted by involving religious institutions and leaders ,Increasing number of Anti-AIDS Clubs (AACs) and intesifing ART adherence counseling.It is also possible to increase IEC by advocating and intesfing VCT, encouraging PLHA to educate about HIV/AIDS and by Contnious education and training of the community to raise awareness.

6.3) HIV Transmission and Prevention

They added on their suggestion about HIV transmission and prevention that abstinence from sex until marriage,being faithful to one partner after marriage are issues to be promoted and advocated.Inaddition,restriction of sex stimulating dances, pornographic films, musics and advertisements that initiate the youth to practice unprotected sex and reducing substance abuse which leads to unsafe sexual practice must be implemented.

6.4) Administrative measure

They finally suggested that taking legal action against illegal video houses and night clubs, incorporating ethics and civics education in the school curricula and increasing number of recreational facilities are things to be paid attention adiministrately.

6. DISCUSSION

The study obtained important informations in assessing barriers to behavioral change towards the prevention of HIV/AIDS. It included those who were 15-49 years with the assumption that wider ranges of sexually active segment of the population were targeted.

Only selected and relevant predictor variables which were statistically significant at the test of bi-variate and multivariate analysis were included in the model. A p-value of less than 0.05 was considered statistically significant for all analyses. Thus, the selected and relevant independent variables were fitted in the binary logistic regression model to examine the effect of each of them on the outcome variable.

Regarding the knowledge related to HIV/AIDS, almost all of the respondents 98.5% heard about HIV and most of them knew at least one mode of transmission and prevention of HIV/AIDS. Moreover, about 87.9 % of the respondents mentioned that the best preventive method of HIV/AIDS was abstinance followed by being faithful to one partner 63.5%. Condom use was indicated as an option of prevention by 49.1% of the respondents.This was supported by in-depth interview. Majority of the respondents explained that HIV/AIDS could be prevented by abstinance, which is consistent with the finding of the study done in three small towns of northern Ethiopia (25), KAP study. Awareness of transmission and prevention of HIV/AIDS was high but unsafe sexual practice among the population was high.

Half (50.9%) of the respondents were unable to mention three major methods of prevention of HIV/AIDS indicating that the level of comprehesive knowledge was still insufficient, which is consistent with the study done in Uganda (20), indicated that almost half of the respondents were unable to name the three major methods of prevention of HIV/AIDS.

When the knowledge of condom 49.1% as preventive method for HIV infection and the Utilization 36% were compared, there was a discrepancy between knowledge and condom utilization,which is consistent to the finding of the Uganda (20), found out that

most of the adult population practice unprotected sex despite the high level of knowledge pertaining to transmission and preventive methods of HIV/AIDS.

Misconceptions related to modes of transmission of HIV/AIDS were high, the most prevalent one being mosquito bites 12.7% followed by eating eggs of hen swallowed used condom 10.8%. Among the respondents 12.7% had at least one misconception related to transmission of HIV/AIDS, which is similar to the finding of Uganda (20) misconceptions among the population were high.

Half (53.8%) of the respondents said that a great behavioral and attitude change towards the prevention of HIV/AIDS was brought by seeing HIV cases and deaths. Similarly, studies done in Uganda (25), which revealed that the number of AIDS deaths known to a respondent may be influencing the change of behavior related to HIV/AIDS.

About 40.3% of the respondents perceived seriousness of HIV. Allmost all the respondents of in-depth interview reported to have high risk- perception of HIV, though some of the segment of the population is still committing unsafe sexual practice.The study in Bahir Dar (30), supported this finding, had shown that the risk perception related to HIV was high amongst the target groups.

Majority 87.2%, of the respondents had sexual practice in the past one year from which only 72.9 % have reported to have only one partner, while about 27.1% had more than one partner. This finding was almost similar to the study in Uganda (20) which demonstrated that almost a third of the sexually active segment of the adult population had more than one partner.

This study showed that the minimum age of sexual commencement was 10 years of age indicating that risky behavior exposing to HIV/AIDS was still prevailing among the population. This finding was consistent with the finding of Bahir Dar study (30), which revealed that the earliest age of sexual contact was 10 years.

Condom utilization rate was 36%, which was low. It was found to be consistent with other studies in Gambella (22) and Rural Ethiopia (29). Gambella (22), showed that condom usage was low among the population despite there was adequate knowledge.

Rural Ethiopia (29) ,indicated that though young people were sexually active at younger age, few of them used condom.

Pertaining to knowledge, attitude and practice related to VCT. Most of the study subjects 88.7% had heard about VCT, out of which 96.1% had favorable attitudes towards VCT. Among those with favorable attitudes, 67.6% had undergone VCT. The others 32.4% had not. This finding is inconsistent with the result of Bahir Dar (30). The magnitude of those who undergone VCT in Bahir Dar (30) study was much less than the result obtained in the current study. This might be attributed to the increase in awareness and availability of VCT service from year to year. But it was similar to other study in Uganda (20) that showed over 70% of respondents were willing to have HIV testing.

Stigma and discrimination was the second reason for not undergoing VCT 35.3% and the main identified barrier to behavioral change 26%, becoming a significant challenge to the prevention and control of HIV/AIDS which is consistent with the finding of the studies done in Amhara Region (26) and Ethiopia (27). Amhara Region (26), it indicated that the majority of respondents showed at least one stigmatizing attitude towards people living with HIV/AIDS. Ethiopia (27), Showed high level of stigma and discrimination related to HIV/AIDS.

The majority of the respondents 69.7% reported that unsafe sexual practices were high. This finding was supported by of the in-depth interview of the current study like having more than one partner, unprotected sex and early commencement of sexual practice among the population was still very high, though majority of the population have adequate knowledge of some modes of transmission and prevention of HIV/AIDS, which is consistent with the finding of the of Bahir Dar study (30), indicated high unsafe sexual practices.

Illlegal video and chat houses, unemployement and traditional malpractice were identified barriers to behavioral change.The qualitative finding also revealed that unsafe sexual practice due to increase in illegal video and chat houses, and unemployement was high.Studies done India (14), Bahirdar (26) and Addis Ababa (28), supported this finding. Addis Ababa (28), the illegal video showing houses and night clubs is criticized

for depiction of contradicting and conflicting messages that arouse sexual feelings through portraying pornographic films and dance. This may distort youth perception resulting in faulty decision which can be considered as one of the perceived barriers to behavioral change. India (14), indicated that the primary cause for spread of HIV infection in Africa is poverty. Bahirdar (26), harmful traditional practices prevailing in the Amhara region are one of the barriers to the prevention of HIV/AIDS.

The other identified barriers towards the prevention were low involvement of the communy, low IEC interventions, low involvement of the religios institution .and gender inequalities, which is consistent with the finding of the studies done in Ethiopia (27). Community – based participation in conjunction with high level of political commitment is the most effective approach in controlling the epidemic. Addis Ababa (28), IEC is a crucial and essential element in society's endeavors against HIV transmission. Addis Ababa (24), religious leaders are becoming the most preferred sources of information in the era of HIV epidemic. It has been reported that they are doing good work because of their source credibility and message believability.India (14), economic inequalities leave women dependent on men for economic reasons and expose them to HIV infection.

The sources of information that helped increase knowledge in order of their importance were health professional, radio, peers and television. This finding was also reviealed in the qualitativthe study. Type of media preferred was similar to the study done in Bahir Dar (30). Another study conducted in Addis Ababa (28) obtained similar results.

The proportion of substance abuse among the respondents in the past one year was high. Chat chewing 20.9% and alcohol drinking 18.5% and cigarette smoking 13.2% were identified substances, this was supported by the qualitative study in which the majority of in-depth interviewees reported that there was high rate of alcohol drinking and chat chewing. The reasons they mentioned for this high rate partialy were unemployement and inadequate recreational facilities.This finding was inconsistent with the finding of the study done in Bahir Dar (30), which indicated that among adult population very low level of drug and alcohol use was reported.The possible reasons could be using substances was increasing from time to time and khat is aboundantely grown as a cash crop.

Using binary logistic regression, the socio- demographic variables were compared with the three selected dependent variables related to behavior, namely, sexual practice, changed previous attitude and condom utilization. Some of the socio-demographic variables showed significant associations with the three outcomes variables.

Age, marital status, education,occupation and income were significantly associated with sexual practices, which is similar to the study done in Bahirdar (30) ,age and marital status were significantly associated with sexual practices.Another study conducted in Uganda (20) revealed that education influence change of behavior in the era of AIDS. Educated individuals have more access to information that enables them to change their behavior before uneducated. Age was observed to influence the behavioral change.

Religion, education, having radio and having television were significantly associated with changed previous attitude.This was triangulated by qualitative study that revealed religion,education and exposure to media could influence on behavior related to HIV/AIDS,which is consistent with study done in Uganda (20), revealed that education influence change of behavior in the era of AIDS. Another study conducted in northern Ethiopia (25), indicated that higher behavioral change was observed as the level of educational status increased from lower to higher level. This is perhaps educated individuals have more access to information that enables them to change their behavior.

Sex, religion, marital status and occupation were significantly associated with condom utilization, which is consistent with study done in Bahirdar (30) sex, marital status, occupation and having radio were significantly associated with condom utilization.

The relationship of the socio-demographic variables with the three outcome variables implied that some socio-demographic factors had influence on behavioral change towards the prevention of HIV/AIDS. This was triangulated by qualitative study that revealed the socio-demographic variables and dwelling area could impact on behavior related to HIV/AIDS. AIDS–risk behaviors remain common in many countries. Some studies on HIV-risk behaviors showed that, despite adequate knowledge about

HIV/AIDS.Higher proportions of people continue to exercise high risk behaviors. Among the high-risk behaviors known to place individuals at risk of HIV infection was having multiple sexual partners.It was the key concern in sub-Saharan Africa. Similarly history of multiple sexual partners was the main risk factor for HIV infection in Ethiopia.

Strengths and limitations of the study

Strengths

Appropriate tests were employed and findings were compared with other related observations locally and internationally. Furthermore, combining quantitative and qualitative data was used to triangulate the findings.

Limitations

Social desirability bias may not be eliminated even though the survey was done anonymously. Finally, this study was based on cross-sectional data, which implies that the direction of causal relationships cannot always be determined.

7. CONCLUSION

- ✓ Majority of the respondents had awareness of HIV/AIDS but the study showed that there was still a discrepancy between knowledge about HIV/AIDS and behavioral change towards the prevention of the disease.
- ✓ The attitude of most of the respondents towards the prevention of HIV/AIDS including the VCT services was favorable but undergoing of VCT still low.
- ✓ Utilization of condom among the urban population was low.
- ✓ Awareness of perceived barriers to behavioral change towards the prevention of HIV/AIDS among the urban population was low, mainly due to illegal video houses and chat houses, unemployement, and traditional malpractice.

8. RECOMMENDATIONS

Based on the findings of the study, the following recommendations were forwarded.

1. Planner and implementer need to strengthen the current IEC strategy in a view of adapting better behavioral change.
2. Kebele administratives and community at large make stronger education to avoid early sexual intercourse and to promote condom utilization..
3. Non-governmental organizations and community at large increasing awareness and expansion of VCT services to bring sustainable behavioral change among the population.
4. Government, non-governmental organizations and community build up legislative actions directed tocontrol khat and illegal video showing houses and increase number of recreational facilities and focus on creation of job opportunities.
5. Community and religious leader support the participation of community and the religious leaders to decrease traditional malpractice and the stigma and discrimination attached to HIV/AIDS.
6. The community increasing media access to the community by letting individuals to have radio by promoting economic development.
7. Manager at all level make stronger health education activities at the health institutions and religious organizations.
8. The researcher conduct further studies related to barriers to behavioral change interventions.

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10. Annexes

Annex-1

University of Gondar

College of medicine and health science

School of public health

Questionnaire identification number----------

Address: kebele----------

1. STRUCTURED INTERVIEW QUESTIONNAIRE FOR THEQUANTITATIVE STUDY

1.1. Guideline for Interviewers

When you reach the selected household, introduce yourself as coming from University of Gondar after greeting the person you meet first. Then explain the purpose of the study for the respondent by saying that:"The reason why I came here is to ask you some questions related to health. The purpose of this interview is to conduct scientific research that may help us to assess perceived barriers to behavioral change and associated factors towards the prevention of HIV/AIDS and forward some recommendations to concerned bodies that will help to improve the existing efforts in the area of HIV/AIDS prevention".After the explanation, identify the presence of any household members aged 15-49 years of age. If they are more than one person in the specified age group, give number for each one and then select one individual by lottery method. If there is no individual in the specified age group, thank and go to the next household.

1.2. Informed Consent

Read the following paragraph for the selected person.

"To conduct our study, I would like to ask you some questions which may take about 30 minutes. As your participation is very important to the outcome of the study, we kindly request you to give us your sincere and truthful answer. All the information that you and other respondents are going to provide us will remain confidential and you don't need to mention your name."

Are you willing to participate in the interview?

Yes, _____ (continue the interview if the respondent says, "Yes")

No, _____ (Thank and stop here if respondent says "No")

Signature_____ Date_____
(Signature of the interviewer certifying that consent has been obtained verbally)

Instruction: - The following are interview questions in order to assess perceived barriers to behavioral change towards the prevention of HIV/AIDS among the population aged 15-49 years in Gondar Town. Please give your honest and truthful answer to each question from the indicated choices.

Part 1. Socio- demographic variables

No	**Questions**	**Alternative responses**	**Skip to**
Q101	Sex of the respondent	1. Male 2. Female	
Q102	What is your age in years?	1. _____(years)	
Q103	What is your religion?	1. Orthodox 2. Catholic 3. Protestant 4. Muslim 5. No religion 6. Others (specify)_____	
Q104	To which ethnic group do you belong?	1. Amhara 2. Agaw 3. Tigre 4. Gurage 5. Oromo 6. Others (specify)_____	

Q105	What is your current marital status?	1.Single 2. Married 3. Divorced 4. Separated 5. Widowed	
Q106	What is the highest level of school you have completed?	1. Cannot read and write 2. Can read and write 3. Grade 1-6 4. Grade 7-12 5. Diploma and above 6. Others (specify)_____	
Q107	What is your current occupational status?	1. Civil servant 2. Housewife 3. Trader 4. Private employee 5. Student 6.Commercial sex worker 7. Daily laborer 8. Others_____	
Q108	What is your income per month?	1. Less than 500 Birr 2. 500- 999 9Birr 3. >1000 Birr and above 4.Refused to answer 88. I do not know 99. No response	
Q109	Is there radio in your household?	1. Yes 2. No	
Q110	Is there television in your household?	1. Yes 2. No	

Part 2. Sexual behavior related to HIV prevention

No	**Questions**	**Alternative responses**	**Skip to**
Q201	Have you ever had sexual Intercourse?	1. Yes 2. No----------	 →Q301
Q202	At what age did you first have sexual intercourse?	1. ----------years 88. I do not know 99. No response	
Q203	Have you had sexual intercourse in the last 12 months?	1. Yes 2. No---------- 88. I do not know 99. No response	 →301
Q204	If your response to Q203 is "Yes" how many sexual partners did you have in the last 12 Months?	1. Only one partner---------- 2. More than one partner 88. I do not know 99. No response	→Q207
Q205	How many of them were regular Partners? (Someone with whom you have been having sex for at least 3 months)	1._____ 88. I do not know 99. No response	
Q206	How many of them were non regular partners? (Someone with whom you have been having sex for less than 3 months)	1._____ 88. I do not know 99. No response	
Q207	In the sexual intercourse of the past 12 months, did you and your partner(s) use condom?	1. Yes 2. No---------- 88. I do not know 99. No response	 →Q209

Q208	If your response to Q207 is "Yes", at what frequency did you and your partner (s), use condoms?	1. Every time 2. Sometimes 3. Rarely 88. I do not know 99. No response	
Q209	Why did not you and your Partner (s) use condoms during sexual intercourse? **(Circle all that apply)**	1. Not available 2. Partner objected 3. Too expensive 4.stigma &discrimination 5. Religious disapproval 6. Do not like them 7. Have trust in the partner 8.Others (specify)_____ 88.I do not know	

Part 3. Communication related to HIV prevention

No	Questions	Alternative responses	Skip to
Q301	Have you ever heard about HIV/AIDS on the radio?	1. Yes 2. No----------	→Q303
Q302	If your response to Q301 is "Yes", how often have you listened to the radio during the last four weeks?	1.At least once a week 2.At least once in two weeks 3.At least once in three weeks 4.At least once in four weeks 5. Others (specify)_____	
Q303	Have you ever watched about HIV/AIDS on the television?	1. Yes 2. No----------	→Q305
Q304	If your response to Q303 is "Yes", how often have you watched to the television during the last four weeks?	1. At least once a week 2. At once in two weeks 3. At once in three weeks 4. At once in four weeks 5. Others (specify)_____	
Q305	During the last four months, have read any printed	1. Yes 2. No	

	materials related to HIV/AIDS? /printed materials refer to newspaper, magazines and leaflets and posters /		

Part 4. Knowledge, attitudes and practices related to HIV prevention.

No	**Questions**	**Alternative responses**	**Skip to**
Q401	When have you first heard about HIV/AIDS?	1. Never heard 2. Since one year 3. Since 2 yeas 4. Since 3 years 5. Since 4 years 6. Since 5 years 7. Before 5 years 88. I do not know 99. No response	
Q402	Have learned anything about HIV/AIDS in the last 12 months?	1. Yes 2. No----------	→Q404
Q403	If you response to Q402 is "***Yes***", what did you learn? **(Circle all that apply)**	1. Modes of transmission of HIV 2. Preventive methods of HIV 3. Impacts of HIV/AIDS 4.Others (specify)_____	
Q404	Which source(s) of information helped you to increase your knowledge related to HIV/AIDS? **(Circle all that apply)**	1. Family 2. Peers 3. Radio 4. Television 5. Leaflets 6. Posters 7. Newspaper 8. Religious leaders 9. Health professionals 10. Teachers	

		11. Anti-AIDS clubs 12. PLWHA 13. Others (specify)_____ 88. I do not know	
Q405	What are the modes of transmission of HIV/AIDS? **(Circle all that apply)**	1. Unprotected sex 2. Contaminated instruments 3. From mother to child 4. Shaking hand with PLWHA 5. Eating with PLWHA 6. Mosquito's bites 7. Unscreened blood transfusion 8. Living with PLWHA in the same house 9. Eating eggs laid by a chicken that has swallowed used condoms 10. Using the same toilet with PLWHA 11.Others (specify)_____ 88. I do not know	
Q406	What are the preventive methods of HIV/AIDS? **(Circle all that apply)**	1. Abstinence 2. Being faithful to one's partner 3. Correct and consistent use of condom 4. Using infected instruments 5. Having good nutrition 6. Voluntary counseling & testing 7.Others (specify)_____ 88. I do not know	
Q407	Did the information you received about HIV/AIDS changed your previous attitudes?	1. Yes 2. No	

Q408	To bring positive behavioral change towards HIV prevention, which setting (s) do you prefer to obtain information related to HIV/AIDS? **(Circle all that apply)**	1. Health institutions 2. Schools 3. Religious organizations 4. Community-based organizations 5. At home level 6.Others (specify)_____	
Q409	Did the information you obtain about HIV/ AIDS	1. Yes 2. No	
Q410	How should information related HIV/AIDS be communicated in order to bring about significant behavioral change? **(Circle all that apply)**	1. Songs 2. Drama 3. News 4. Speeches 5. Discussions 6.) Others (specify)_____	
Q411	Do you know people who are infected with HIV or have died of AIDS?	1. Yes 2. No----------	→Q413
Q412	If your response to Q411 is "Yes", how do you rate the positive behavioral change you have noticed due to the Infection or deaths?	1. Great change 2. Some change 3. No change 88. I do not know 99. No response	
Q413	Do you think that a healthy–looking person can be infected with HIV?	1. Yes 2. No	
Q414	How much do you think is your chance of contracting HIV infection with one unprotected sexual intercourse?	1. Very high 2. Very low 3. Medium 4. I do not think I will contract HIV 88. I do not know 99. No response	

Q415	Have you heard about VCT?	1. Yes 2. No----------	→Q419
Q416	If your answer to 415 is "Yes" what is your attitude towards the VCT service?	1. Good 2. Bad 88. I do not know 99. No response	
Q417	If your response to Q416 is ***good***, have you undergone VCT?	1. Yes---------- 2. No	→Q419
Q418	If your response to Q417 is "***No***" why? **(Circle all that apply)**	1. Service is not accessible 2. Cost is high 3. Fear of positive results 4. Fear of stigma and discrimination 5.Others(specify)_____ 88. I do not know 99. No response	
Q419	Have you Everbeen addicted to any one of the followings during your lifetime? **(Circle all that apply)** **/ "Drug" refers to drugs other than** **drugs for treatment /**	1. Chat chewing 2. Alcohol drinking 3. Cigarette smoking 4. Drug use 99. No response----------	→Q421
Q420	Have you been experiencing any one of the followings during the last 12 months regularly? **(Circle all that apply)** **/ "Drug" refers to drugs other than** **drugs for treatment /**	1. Chat chewing 2. Alcohol drinking 3. Cigarette smoking 4. Drug use 99. No response	

Q421	How much is unsafe sexual behavior in light of seriousness of HIV/AIDS in the urban community at Present time?	1. Increased 2. No change 3. Decreased---------- 88. I do not know 99. No response	→Q423
Q422	If your response to Q421 is **"***Increased"* or "*No change,*" what are the barriers to the behavioral change towards the prevention of HIV/AIDS? **(Circle all that apply)**	1. Low IEC efforts 2. Increase in number of illegal video houses. 3. Low involvement of the community 4. Low involvement of the religious. 5. Traditional malpractices 6. Lack of recreational areas 7. Stigma and discrimination 8. Gender inequalities 9. Unemployment 10.Others(specify)_____ 88. I do not know	
Q423	What do you recommend to overcome the barriers to behavior change towards HIV prevention? **(Circle all that apply)**	1. Strengthen the IEC activities 2.Increase№ of the religious organizations 3. Increase involvement of the community 4. Women empowerment 5. Strengthen school health education 6. Remove stigma and discrimination 7. Taking legal measures on illegal video houses 8. Others (specify)_____ 88. I do not know	

This is the end of the interview. Thank you very much for your answering the questions.

ANNEX 1.1

TOPIC GUIDELINE FOR INDEPTH INTERVIW

1. What do you perceive about HIV/AIDS? (Means of transmission and prevention as well as attitudes towards the prevention)
2. Is the behavioral change towards the prevention of HIV among the urban community is low or high? If low, what are the barriers? If high, what were the favorable conditions? (Probing is very important).
3. Among the following socio-demographic factors, which ones have impacts on behavioral change towards HIV prevention? (Sex, age, religion, ethnicity, marital, educational, economic and occupational statuses as well as residence.)
4. What are the important sources of information for positive behavioral change towards HIV/AIDS prevention?
5. Discuss on the impacts of IEC activities on behavioral change towards HIV/AIDS Prevention?
6. Do you suggest another means of bringing about positive behavioral change in order to curtail the fast spread of HIV/AIDS among the urban the community?

This is the end of our discussion. Thank you very much for your participation in the discu

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ህክምና እና ጤና ሳይንስ ኮሌጅ

መለያ ኮድ----------

አድራሻ(ቀበሌ)----------

ለሣይንሣዊ ምርምር የተዘጋጀ የቃለ መጠይቅ ቅጽ

1. የቃለ መጠየቅ መመሪያ ፡-

   ከተመረጠው ቤት አንደደረስክ በመጀመሪያ ቤት ውስጥ ላለ ሰው ሥላምታ ታቀርባለህ ከዛም ከጎንደር ዩኒቨርስቲ አንደመጣህ ራስህን ታስተዋውቃለህ ቀጥለህም የጥናቱን ዓላማና ጥቅም እንዲህ በማለት ታብራራለህ፡፡

ወደዚህ የመጣሁበት ምክነያት ጤና ነክ የሆኑ ጥቂት ጥያቄዎችን ለመጠየቅ ነው፡፡ የቃለ መጠይቁ አላማና ጥቅሙ ኤች አይ ቪ /ኤድስን / ለመከላከል የባህሪ ለውጥ ለማምጣት የህብረተሰቡን እውቀት፣ዝንባሌ፣ ተግባራዊ እንቅስቃሴ ና ተዛማጅ ችግሮችን ለመዳሰስ ሣይንሣዊ ጥናት በማድረግ ለማመለከተው አካል በሀሣብ በማቅረብና የጥናቱ ውጤት በመግለፅ አሁን ኤች አይ ቪ ዙሪያ ላይ እየተደረገ ያለውን የመከላከል ጥረት የበለጠ ለማጠናከርና አደዲስ ስልቶችን ለመቀየስ አንደረዳ ነው፡፡ ገለፃውን ካደረክ /ሽ/ በኋላ 15—49 እድሜ ክልል ውስጥ ያሉ የቤተሰብ አባላትን ትለያለህ /ሽ/ ፡፡ በዚህ እድሜ ክልል ያሉ የቤተሰብ አባላት ከአንድ በላይ ከሆኑ ለእያንዳንዳቸው ቁጥር በመስጠት በዕጣ አንዱን ትመርጣለህ በዚህ እድሜ ክልል ውስጥ ምንም ሰው ከለለ አመስግነህ ወደ ሚቀጥለው ቤት ትሄዳለህ፡፡

2. ቃለ መጠይቁን ለመሙላት የተደረገ የቃል ስምምነት ፡-

የሚከተለውን አንቀጽ ለተመረጠው ሰው ታነብለታለህ/ ሽ/ የገለፅኩልህን /ሽን/ ጥናት ለማካሄድ ይረዳ ዘንድ ለ 30 ደቂቃዎች ያክል ጥያቄዎች ልጠይቅህ/ሽ / እወዳለሁ ፡፡ ለጥናቱ ውጤታማነት ያአንተ /የአንቺ/ ተሣትፎ እጅግ አስፈላጊ ስለሆነ ቀጥተኛና እውነተኛ የሆነ መልስ እንድትሰጠን /ጪ/ በማከበር እንጠይቃለን ፡፡

አንቲም/ አንቺም/ ሆነ ሌሎች አንተን/ አንቺን / መሰል መልስ ሰጪዎች የምትሰጡት ማንኛውም መረጃ በሚስጥር የተጠበቀ ነው፡፡ ስምህን/ ስምሽን/ መግለጽ አያስፈልግም፡፡

በቃለ መጠይቁ ለመሣተፍ ፈቃደኛ ነህ/ሽ/ ?

አዎ - - - -- - - ቃለ መጠይቁን ማካሄድ

አይደለም - - - - - - ቃለ መጠይቁን ማቆም እና አመስግነህ መሄድ

የጠያቂው ፊርማ ----------

የቃል ስምምነት እንደተደረገ ለማረጋገጥ ቃለ መጠይቁ ጠያቂ ፊርማ መኖር አለበት ፡፡

ትዕዛዝ

የማከተሉትን ጥያቄዎች ኤች አይቪ /ኤድስን / ለመከላከል የሚረዱ የባህሪ ለውጥ ለማምጣትእንቅፋት የሆኑ ነገሮችን ለመለየት ና የህብረተሰቡን እውቀት፣ዝንባሌ፣ ተግባራዊ እንቅስቃሴ ና ተዛማጅ ችግሮችን ለመዳሰስ ሣይንሣዊ ጥናት ለማድረግ የሚያስችሉ ቃለ መጠይቆች ናቸው ፡፡ እባክዎ ቀጥተኛና እውነተኛ መልስ በመስጠት ይተባበሩን

ክፍል-- አንድ ማህበራዊና ስነ ህዝባዊ መጠይቆች ፡-

ተ.ቁ	ጥያቄዎች	አማራጭ መልሶች	ዝለለው
ጥ.1ዐ1	ፆታ	1 ወንድ 2. ሴት	
ጥ.1ዐ2	እድሜ /በአመት/	1.----------/ ዓመት /	
ጥ.1ዐ3	ኃይማኖት	1. ኦርቶዶክስ 2. ካቶሊክ 3. ፕሮቴስታንት 4. እስላም 5. ኃይማኖት የሌለው 6. ሌላ ካለ ይጠቀስ ----------	
ጥ.1ዐ4	ብሄረሰብ	1. አማራ 2. አገው 3. ትግራይ 4. ጉራጌ 5. ኦሮሞ 6. ሌላ ካለ ይጠቀስ----------	
ጥ.1ዐ5	የጋብቻ ሁኔታ	1. ያላገባ 2. ያገባ 3. የፈታ 4. ተለያይቶ የሚኖር ባልና ሚስት 5. የሞተበት	
ጥ.1ዐ6	የትምህርት ደረጃ	1. ማንበብ መፃፍ የማይችል 2. ›› ›› የሚችል 3. 1—6ኛ ክፍል 4. 7—12ኛ ክፍል 5. ዲፕሎማና ከዚያ በላይ 6. ሌላ ካለ ይጠቀስ ----------	

ጥ.1ዐ7	የሥራ ሁኔታ	ነ. የመንግስት ሠራተኛ 2. የቤት እመቤት 3. ነጋዴ 4. የግል ተቀጣሪ 5. ተማሪ 6. ሴተኛ አዳሪ 7. የቀን ሠራተኛ 8. ሌላ ካለ ይጠቀስ ----------	
ጥ.1ዐ8	የወርሃዊ ገቢ መጠን ስንት ነው ?	1. < 500 2. 500 – 999 ብር 3. >1000 5. መልስ ለመስጠት ፈቃደኛ ያልሆነ 88. አላውቅም 99. መልስ የለም	
ጥ.1ዐ9	በቤት ውስጥ ራዲዮ አለ?	1. አዎ 2. የለም	
ጥ.11ዐ	በቤት ውስጥ ቴሊቪዥን አለ?	1. አዎ 2. የለም	

ክፍል ሁለት ኤች አይ ቪን ለመከላከል ተያያዥነት ያላቸው ውስጣዊ ባህሪያት ፡-

ተ.ቁ	ጥያቄዎች	አማራጭ መልሶች	ዝለለው
ጥ.2ዐ1	የግብረ ስጋ ግንኙነት አድርገህ/ሽ/ ታውቃለህ?	1. አዎ 2. የለም ---------- →	301
ጥ.2ዐ2	በስንት ዓመትህ ነው የመጀመሪያ የግብረ ስጋ ግንኙነት ያደረከው /ሽው/?	1. ----------ዓመት 88, አላውቅም 99. መልስ የለውም	
ጥ.2ዐ3	ባለፉት 12 ወራት ውስጥ የግብረ ስጋ ግንኙነት አድርገሃል ወይ ?	1. አዎ 2. የለም ------ - - - - - - - - → 88. አላውቅም 99, መልስ የለም	3ዐ1
ጥ.2ዐ4	ለጥያቄ 2ዐ3 መልስ አዎ ከሆነ ስንት የወሲብ ጋደኛ አለህ(ሽ)ባለፉት 12 ወራት ውስጥ ?	1. አንድ ብቻ - - - - -- - --- --- → 2. ከአንድ በላይ 88. አላውቅም 99. መልስ የለውም	- 2ዐ7
ጥ.2ዐ5	ከስንቶቹ ጋር ተከታታይ የሆነ ግንኙነት አለህ/ ሽ/ የወሲብ ጋደኛ /ቢያን ለ 3 ወር አብሮ የቆየ/ ?	1. ---------- 88. አላውቅም 99. መልስ የለውም	
ጥ.2ዐ6	ከስንቶቹ ጋር ነው ቋሚ ያልሆነ ግንኙነት ያለህ (ሽ)የወሲብ ጋደኛ?/ከ3 ወር በታች /	1. ---------- 88. አላውቅም 99. መልስ የለም	
ጥ.2ዐ7	ባለፉት 12 ወራት ውስጥ ባደረካቸው /ሽ/ የግብረ ሥጋ ግንኙነት አንተና/ቺ/ና ጓደኛሽ /ህ/ ኮንዶም ትጠቀማላችሁ ወይ?	1. አዎ 2. የለም ----- - - - - - --- - - → 88. አለውቅም 99 መልስ የለም	2ዐ9

ጥ.2ዐ8	ለጥ. 2ዐ7 መልሱ አዎ ከሆነ ለስንት ያህል ጊዜ አንተና/ቺ/ና ጓደኛሽ /ህ/ ተጠቅማችኋል ?	1. ሁል ጊዜ 2. አንዳንድ ጊዜ 3. በጣም አልፎ አልፎ 88. አላውቅም 99. መልስ የለም	
ጥ.2ዐ9	አንተና/ቺ/ ና ጓደኛሽ ግብረ ስጋ ግንኙነት ስትፈፅሙ ኮንዶም የማትጠቀሙበት ምክንያት ምንድን ነው ? መልሶችን አክብብ	1. በቅርብ አይገኝም 2. ጓደኛየ ስለሚቃወም 3. በጣመ ውድ ስለሆነ 4. ታይማኖቴ ስለማይፈቅድ 5. መገለል አና መድሎ ስለምፈራ 6. ስለማልወደው 7. ጓደኛየን ስለማምን 8. ሌላ ካለ ይጠቀስ---- --- 88. አላውቅም	

ክፍል - 3 ከኤች አይ ቪ መከላከል ጋር ተያያዥነት ያላቸው ተግባራት

ተ.ቁ	ጥያቄዎች	አማራጭ መልሶች	ዝለለው
ጥ.3ዐ1	ስለ አች አይ ቪ ኤድስ በሬድዬ ሰምተህ ታውቃለህ ?	1. አዎ 2. የለም - - ---- ⟶	3ዐ3
ጥ.3ዐ2	የጥያቄ 3ዐ1 መልስህ አዎ ከሆነ ላለፉት 4 ሣምንታት ለስንት ያህል ጊዜ አዳምጠሃል ?	1. ቢያንስ በሣምንት 1 ጊዜ 2. ›› በ 2 ›› 1 ›› 3. ›› በ 3 ›› 1 ጊዜ 4. ›› በ 4 ሣመንት 1 ጊዜ 5. ሌላ ካለ ይጠቀስ -----	
ጥ.3ዐ3	በቴሊቪዥን ስለ ኤች አይቪ ኤድስ ተመልክተህ ታውቃለህ ?	1. አዎ 2. የለም - - - - - - ⟶	3ዐ5
ጥ.3ዐ4	ለጥያቄ 3ዐ3 መልስህ አዎ ከሆነ ላላፈት 4 ሣምንታት ለምን ያህል ጊዜ ተመልክተሃለ ?	1. ቢያንስ በሣምንት 1 ጊዜ 2. በ2 ሣምንት 1 ጊዜ 3. በ3 ›› 1 ጊዜ 4. በ4 ›› 1 ጊዜ 5. ሌላ ካለ ይጠቀስ	
ጥ.3ዐ5	ላለፉት 4 ወራት ከኤች አይ ቪ ኤድስ ጋር ተያያዥነት ያላዠው ፅሑፎችን አንብበህ ታውቃለህ ወይ ? /ጋዜጣ ፣መፅሔት፣ በራሪ ወረቀት እና ስዕላዊ መግለጫዎች /	1. አዎ 2. የለም	

ክፍል አራት ኤች አይ ቪ መከላከለ ጋር ተያያዥነት ያለው አውቀት አመለካከትና ተግባራት አንቅስቃሴ

ተ.ቁ	ጥያቄዎች	አማራጭ መልሶች	ዝለለው

ጥ.4ዐ1	ለመጀመሪያ ጊዜ ስለ ኤች አይ ቪ ኤድስ የሰማኸው መቼ ነው ?	1. ሰምቶ አላውቅም 2. ከ1 ዓመት ወደህ 3. ከ2 ዓመት ወዲህ 4. ከ3 ›› ›› 5. ከ4 ›› ›› 6. ከ5 ›› ›› 7. ከ 5 ›› በፊት 88. አላውቅም 99. መልስ የለም	
ጥ.4ዐ2	ባለፉት 12 ወራት ውስጥ ስለ ኤችአይቪኤድስ ተምረሃል/አውቀሃል	1. አዎ 2. የለም -- - - - - -- - - - →	4ዐ4
ጥ.4ዐ3	የጥያቄ 4ዐ2 መልስ አዎ ከሆነ ምን ተማርክ ወይስ ምን አወክ ?	1. ኤችአይቪመተላለፊያ መንገድ 2. ኤችአይቪመከላከያመንገድ 3. ኤችአይቪ ያመጣው ተጽኖ 4. ሌላ ካለ ይጠቀሥ	
ጥ.4ዐ4	ስለ ኤች አይ ቪ /ኤድስ/ ያለህን ዕውቀት ለማዳበር የረደህ የመረጃ ምንጭ የትኛው ነው ?	1.ቤተሰብ 2.ጓደኛ 3. ሬዲዬ 4. ቴሌቪዥን 5. በራሪ ወረቀት 6. ስዕላዊ መግለጫዎች 7. ጋዜጣ 8. የሃይማኖት መሪዎች 9.የጤና ባለሙያዎች 1ዐ. መምህራን 11. ፀረ- ኤድስ ክበብ 12. ቫይረሱ በደማቸው ውስጥ ያለባቸው ሰዎች 13. ሌላ ካለ ------ 88. አላውቅም	

ጥ.405	ኤችአየፊ/ኤድስ/ መተላለፊያ መንገዶች የትኞቹ ናቸው ? /መልስህን አክብብ /	1.ጥንቃቄ የጎደለው የግብረ ስጋ ግንኙነት 2.ከደምጋርየተነካኩየህክም መሣሪያዎች 3. ከእናት ወደ ልጅ 4. ቫይረሱ በደማቸው ውስጥ ካለባቸው ሰዎች ጋር መጨባበጥ 5. ቫይረሱ በደማቸው ውስጥ ካለባቸው ሰዎች ጋር አብሮ በመብላት 6. በወባ ትንኝ 7. ያልተመረመረ ደም ሲሰጥ 8. ቫይረሱ በደማቸው ውስጥ ካለባቸው ሰዎች ጋር አብሮ በመኖር 9. ኮንዶሙን የዋጠች ደሮ የጣለችውን እንቁላል በመብላት 10. ቫይረሱ በደማቸው ውስጥ ካለባቸው ሰዎች ጋር አብሮ ሽንት ቤት በመጠቀም 11. ሌላ ካለ ይጠቀስ - - - - - - - 88. አላውቅም	
ጥ.406	ኤች አይቪ/ኤድስ/ መከላከያ ዘዴዎች እነማን ናቸው ? /የትኞቹ ናቸው/መልስን አክብብ /	1. መታቀብ 2. መታመን 3. በትክክለኛው እና ሁል ጊዜ ኮንዶም መጠቀም 4. የተበከሉ መሣሪያዎችን መጠቀም 5. የተመጣጠነ ምግብ መመገብ 6. በፈቃደኝነት ላይ የተመሠረተ የምክርና የምርመራ አገልግሎት ማግኘት 7. ሌላ ካለ ይጠቀስ - - - -- 88. አላውቅም	
ጥ.407	ስለ ኤች አይቪ/ኤድስ ያገኘነው መረጃ ከዚህ በፊት የነበረህን አመለካከት ለውጦልሀል /ሻል/	1. አዎ 2. የለም	

ጥ.408	ስለ ኤች አይ ቪ መከላከል አዎንታዊ የባህሪ ለውጥ ለማምጣት ከየትኛው ተቋም መረጃ ብታገኝ ትመርጣለህ ? / መልስህን አክብ /	1. ከጤና ተቋም 2. ከትምህርት ቤት 3. ከኃየማኖት ድርጅት 4. ከማ/ሰብ አቀፍ ድርጅት 5. ከቤት 6. ሌላ ካለ ይጠቀስ - - - - 7. አላውቅም	
409	ስለኤች አይቪ ኤድስ ያገኘኸው መረጃ የነበረኸን ተግባራዊ እንቅስቃሴ አሻሽሎታል ወይ?	1. አዎ 2. የለም	
410	መሰረታዊ የሆነ የባህሪ ለውጥ ለማምጣት ስለኤች አይቪ/ኤድስ ትምህርት/መረጃ/ እንደት ቢተላለፍ ይሻላል? /መልሶችህን አክብብ/	1. በሙዚቃ/በመዝሙር/ 2. በትዕይንት 3. በዜና 4. በንግግር 5. በውይይት 6. ሌላ ካለ ይጠቀስ	
411	በኤች አይቪ/ኤድስ የተያዙ /የሞቱ/ ታውቃለህ/ሽ/?	1. አዎ 2. የለም---------- →	413
412	የጥያቄ 411 መልሱ አዎ ከሆነ በኤች አይቪ/ኤድስ/ መያዝና መሞት ምክንያት የተገነዘብከውን አዎንታዊ የባህሪ ለውጥ እንዴት ትለካዋለህ?	1. ታላቅ ለውጥ 2. መጠነኛ ለውጥ 3. ምንም ለውጥ የለም 88. አላውቅም 99. መልስ የለም	
413	ጤናማ መስሎ የሚታይ ሰው በኤች አይቪ ሊያዝ ይችላል ብለህ ታስባለህ/ስ/?	1. አዎ 2. የለም	
414	ባንድ ጊዜ በተደረገ ጥንቃቄ የጎደለው የግብረ ስጋ ግንኙነት በኤች አይቪ የመያዝ እድልህ /ሽ/ ምን ያክል ነው ብለህ /ሽ/ትገምታለች/ህ/?	1. በጣም ከፍተኛ 2. በጣም ዝቅተኛ 3. መካከለኛ 4. እያዛለሁ ብየ አላስብም 88. አላውቅም 99. መልስ የለም	

415	ስለበጎፍቃደኝነት የተመሰረተ የምክር አገልግሎትና ምርመራ ሰምተህል/ሻል/ወይ?	1. አዎ 2. የለም ----------→	419
416	የጥ. 415 መልስህ/ሽ/ አዎ ከሆነ ስለበጎፈቃደኝነት ላይ የተመሰረተ የምክርና የምርመራ አገልግሎት ያለህ አመለካከት እንዴት ነው?	1. ጥሩ 2. መጥፎ 88. አላውቅም 99. መልስ የለም	
417	የጥ. 416 መልስህ ጥሩ ከሆነ በፈቃደኝነት ላይ የተመሰረተ የምክር አገልግዘለትና ምርመራ አድርገህል ወይ?	1. አዎ----------→ 2. የለም	419
418	የጥ.417 መልስህ የለም ከሆነ ለምን /መልስህን አክብብ/	1. አገልግሎት አላገኝም 2. ከፍተኛ ክፍያ ስላለው 3. አለብህ የሚባለውን ውጤት ስለምፈራ 4. መገለል እና መድሎን ስለምፈራ 5. ሌላ ካለ ጥቀስ ----- 88. አላውቅም 99. መልስ የለም	
419	ከሚከተሉት መድሀኒቶች በህይወት ዘመንህ ውስጥ ባንዱ ሱሰኛ ሁነህ ታውቃለህ ወይ? /መልሶችህን በሙሉ አክብብ/ በመድሀኒት ስንል ለህክምና ከሚሰጡት መድሀኒቶች ውጭ ነው፡፡	1. ጫት መቃም 2. አልኮል መጠጣት 3. ሲጋራ ማጨስ 4. መድሀኒት መጠቀም 99. መልስ የለም ----------→	421
420	ላለፉት 12 ወራት ከዚህ በታች የተዘረዘሩትን በተከታታይ ስትፈጽም ነበር ወይ? /መልስህን አክብብ/ በመድሀኒት ስንል ለህክምና ከሚሰጡት መድሃኒቶች ውጭ ነው፡፡	1. ጫት መቃም 2. አልኮል መጠጣት 3. ሲጋራ ማጨስ 4. መድሀኒት መጠቀም 99. መልስ የለም	

421	ባሁኑ ስዓት በከተሜው ማህበረሰብ ውስጥ በኤች አይቪ/ኤድስ/ አደገኛነት ላይ ጥንቃቄ የጎደለው የግብረ ስጋ ግንኙነት ባህሪ አሉታዊ ተፅኖ እንዴት ነው?	1. ጨምሯል 2. ምንም ለውጥ የለም 3. ቀንሷል ----------→ 88. አላውቅም 99. መልስ የለም	423
422	የጥ. 421 መልስህ ጨምሯል ወይም ምንም ለውጥ የለም ከሆነ ኤች አይቪ ኤድስን ለመከላከል የባህሪ ለውጥ ለማምጣት እንቅፋት /ማነቆ/ የሆኑት ነገሮች ምን ምን ናቸው? /መልሶችህን አክብብ/	1. የመረጃ የትምህርት እና የተግባበት ጥረት ማነስ 2. የወሲብ ስሜት የሚቀሰቅሱ ህገወጥ ቪዲዮ የሚያሳዩ ቤቶች መብዛት 3. የህ/ብ ተሳትፎ ዝቅተኝነት 4. የሀይማኖት ድርጅቶች ተሳትፎ ማነስ 5. ጎጂ ባህላዊ ልማዶች 6. የመዝናኛ ቦታዎች አለመኖር 7. መገለልና መድሎ ከኤች አይቪ ጋር መያያዝ 8. ጾታዊ አድሎ 9. ስራ አጥነት 10. ሌላ ካለ ጥቀስ 88. አላውቅም	
423	ኤች አይቪ ኤድስን ለመከላከል የባህሪ ለውጥ ለማምጣት እንቅፋት/ ማነቆ/የሆኑትን ለማስወገድ እንዲቻል ምን ሀሳብ /አስተያየት/ ትሰጣለህ/ሽ/?	1. የመረጃ የት/ት እና የተግባቦት እንቅስቃሴዎችን ማጠናከር 2. የሀይማኖታዊ ድርጅቶችን ተሳትፎ ከፍ ማድረግ 3. የህ/ሰቡን ተሳትፎ መጨመር 4. የሴቶችን አቅም ማሳደግ 5. ኤች አይቪን በተመለከተ የት/ቤት የጤና ትምህርትን ማጠናከር 6. መገለልና መድሎን ማስወገድ 7. በህገወጥ ቪዲዮ ቤቶች ላይ ህጋዊ ርምጃ መውሰድ 8. ሌላ ካለ ይጠቀስ 88. አላውቅም	

ቃለ መጠየቁን ጨርሰናል ጥያቄዎችን ስለ መለስክልኝ/ሽ/ በጣም አመሰግናለሁ::

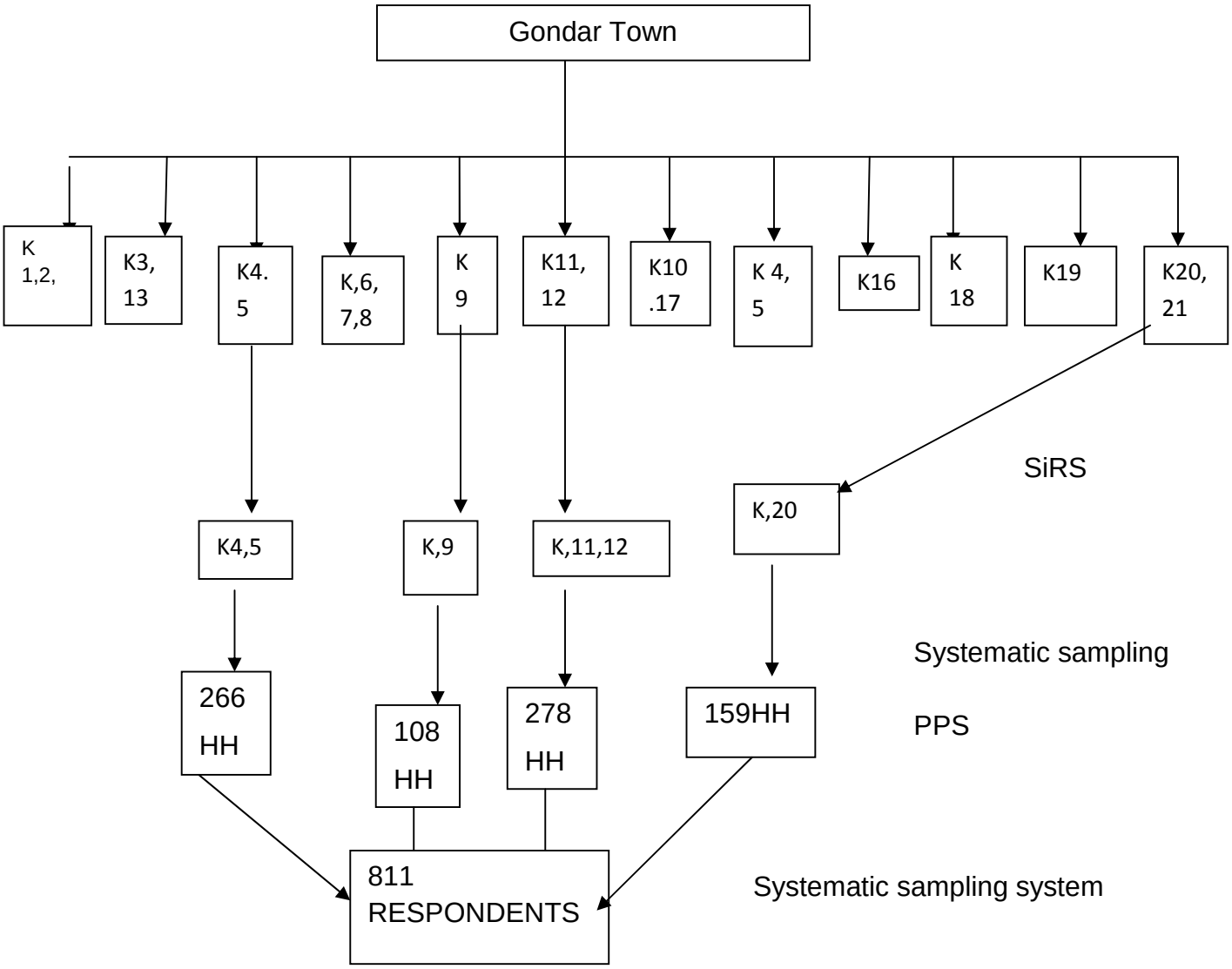
አኔክስ .1.1

<u>በጥልቀት የመጠየቂያ መመሪያ ርዕስ</u>

1. ስለኤች አይቪ ኤድስ ምን ተገነዘባችሁ**?/** የመተላለፊያና የመከላከያ መንገዶች እንደሁም ስለመከላከል ያላችሁ አመለካከት/
2. በከተሜው ማ/ብ ውስጥ ኤች አይቪን የመከላከል ያለው የባህሪ ለውጥ ዝቅተኛ ነው ወይስ ከፍተኛ? ዝቅተኛ ከሆነ እንቅፋቶቹ /ዋነኛዎቹ/ ምን ምን ናቸው**?** ከፍተኛ ከሆነ ይህን ለማድረግ የነበሩት ምቹ ሁኔታዎች ምን ምን ናቸው**?** /በጥልቀት መመርመር በጣም አስፈላጊ ነው/
3. ኤች አይቪን ለመከላከል የባህሪ ለውጥ ለማምጣት ተፅዕኖ የሚያሳድሩ ከሚከተሉት ማህበራዊና ስነህዝባዊ ምክንያቶች የትኞቹ ናቸው**?** /ዕታ፣ዕድሜ፣ ሀይማኖት፣ ብሄር፣ የጋብቻ ሁኔታ፣ የትምህርት ደረጃ፣ የገቢና የስራ ሁኔታ እንዲሁም የመኖሪያ አካባቢ/
4. ኤች አይቪ ኤድስን ለመከላከል አዎንታዊ የባህሪ ለውጥ ለማምጣት በጣም የሚጠቅም የመረጃ ምንጭ የትኞቹ ናቸው**?**
5. የመረጃ ትምህርት እና ተግባራት ኤች አይቪ/ኤድስን ለመከላከለ በባህሪ ለውጥ ላይ ያላቸው አስተዋጽኦ ተወያዩ**?**
6. ኤች አይቪ/ኤድስ / በከተሜው ማህበረሰብ ውስጥ ያለው ከፍጥነት የመስፋፋት ሁኔታ የሚገባ አዎንታዊ የባህሪ ለውጥ ማምጣት የሚያስችሉ ሌሎች ስልቶች ታቀርባላችሁ**?**

ውይይቱን ጨርሰናል በውይይቱ ስለአደረጋችሁት ከፍተኛ ተሳትፎ እጅግ በጣም እናመሰግናለን፡፡

Annex 2. Schematic presentation of the sampling procedure



KEY:

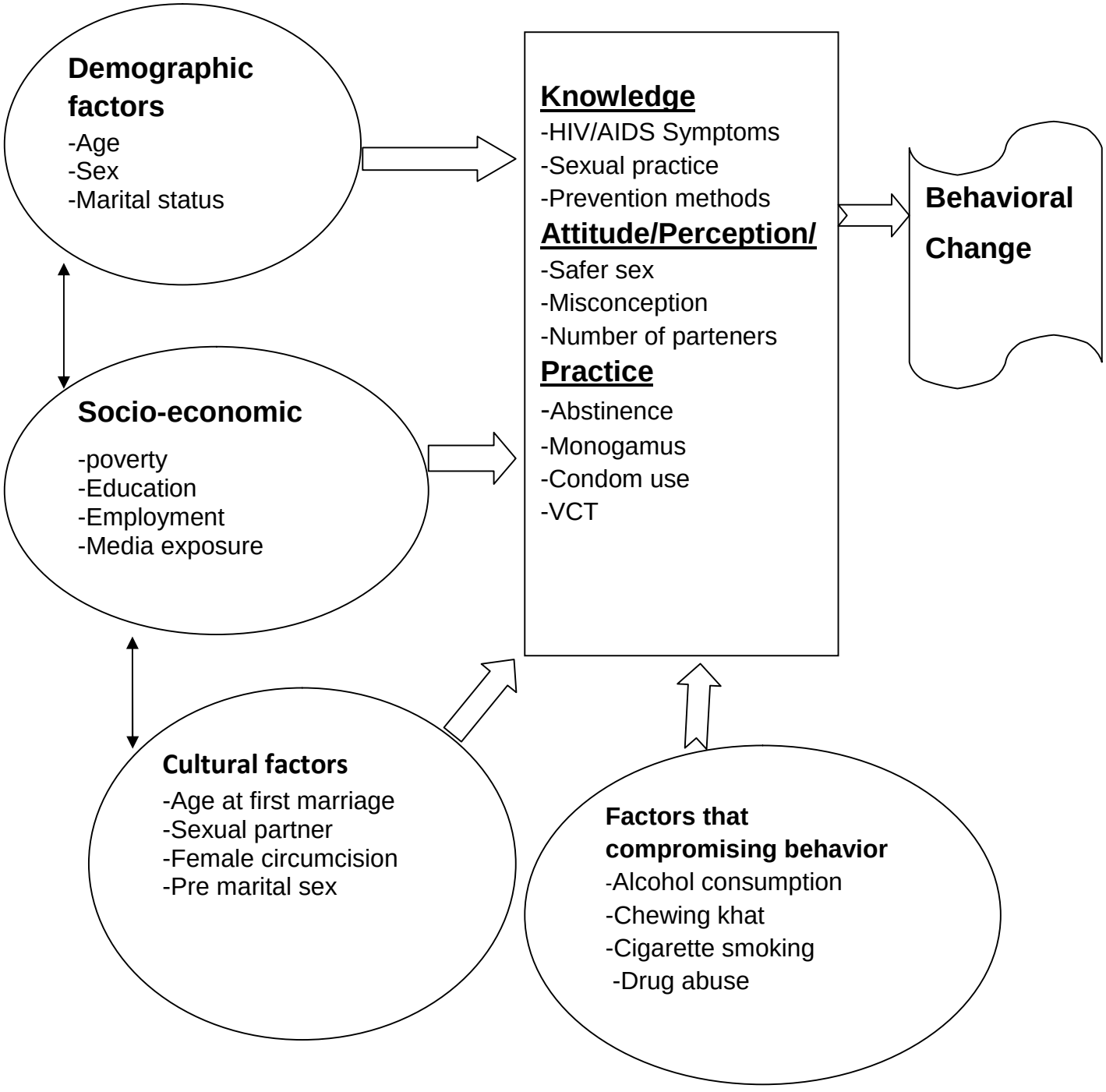
SiRS---simple random sampling

K------Kebele

HH--- Households

PPS---proportionate-to-population size

Annex 3- Conceptual framework on perceived barriers to behavioral change



Annex 4- INFORMATION SHEET AND CONSENT FORM

TITLE OF THE RESEARCH PROJECT

ASSESSMENT OF PERCEIVED BARRIERS TO BEHAVIORAL CHANGE TO WARDS THE PREVENTION OF HIV/AIDS AMONG URBAN COMMUNITY OF GONDAR TOWN NORTH GONDAR ADMINISTRATIVE ZONE, NORTH WEST ETHIOPIA.

Name of principal investigator Aregash Molla

Name of the organization: School of public health, Gondar College of Medicine and Health science, University of Gondar.

Name of the sponsor- Self.

Information sheet and consent form prepared for Urban Community in Gondar town whose age group of 15-49.

Introduction

This information sheet and consent form is prepared with the aim of explaining the research project that you are asked to join by the group of research investigators.

The main aim of this research project is to assess perceived barriers to behavioral change towards the prevention of HIV/AIDS among the population aged 15-49 years in Gondar Town The research group includes 1 principal investigator, 10 trained community counselors and data clerks, 2 BSC nurses as supervisors from Gondar health center and 2 advisors from University of Gondar.

Purpose of the research project

The aim of this study is to assess perceived barriers to behavioral change towards the prevention of HIV/AIDS among the population aged 15-49 years in Gondar Town. In study done in other area showed that urban community has high knowledge about prevention of HIV/AIDS but attitude and practice very low as compared with knowledge for different reasons.

Therefore there should be substantial change in attitude and practice towards the prevention of HIV/AIDS in order to prevent and control HIV/AIDS.Knowledge is netting without positive attitude and highly active practice. To prevent transmission of mother to child and transmission through traditional malpractice and rescue generation. An enormous work should be done on barriers towards prevention of HIV/AIDS. Thus this research will use for Governmental and Non-governmental organization particularly for those working on HIV/AIDS.As an initial work to study further. So, this study focuses in

assessing perceived barriers to behavioral change with behavioral change towards the prevention of HIV/AIDS in Gondar town, North Gondar Zone.

Procedure:

At this study involves Urban Community in Gondar town whose age group of 15-49. Selected by Multi-stage sampling and lottery method. You are selected for this study because you are member of the community and other peoples also participate in the study.

In order to assess perceived barriers to behavioral change towards the prevention of HIV/AIDS in Gondar town, we kindly invite you to take part in our project. If you are willing to practice in our project we are so happy for you to participate in this study and we need you to clearly understand the aim of this study and to sign the consent form. Then you are kindly requested to give your response to the data collectors.

For this questionnaire based study, study subjects are Urban Community in Gondar town whose age group of 15-49 and selected by Multi-stage sampling procedure and who are volunteer to participate in the study. All the response given by participants and the result obtained will kept confidentiality by using coding system whereby no one will have to access to your response.

Risk and /or discomfort

By participating in this research project you may feel that it has some discomfort especially on wasting your time(a maximum of 30 minutes) but this may not be too much as you are one of the member of the community. So your response will help as an important input to show the gap and the means to improve barriers of the prevention of HIV/AIDS. There is no risk to participating in this research project.

Benefits

If you are participating in this research project, there may not be direct benefit to you but your participation is very important to identify barriers and associated factors to behavioral change and the main reason and gap between knowledge, attitude and practice.It is also very helpful to provide accurate information and appropriate counseling for HIV /AIDS.

Incentives/ payments for participating

You will not be provided any incentive or payment to take part in this project.

Confidentiality

The information collected for this research project will kept confidential and information about you that will be collected by this study will be stored in a file, without your name, but a code number assigned to it. And it will not be revealed to anyone except the principal investigator and assistants will be kept locked with key.

Right to refusal

You have the full right to refuse from participating in this research. (you can choose not to response some or all the questions) and this will not affect from getting any kind of HIV care services. You have also the full right to leave from this study at any time you wish, without losing any of your right.

Person to contact

This research project will be reviewed and approved by the ethical committee of the University of Gondar. If you want to know more information you can contact the committee through the address below. If you have any question you can contact any of the following individuals and may ask at any time you want.

1. Aregash Molla,(BSC)
   Mobile: +251-19-18 72-38-58 / e-mail: aregashmd@gmail.com

2. Ato Amsalu Feleke (associate proff.): University of Gondar
   Mobile: +251-19-18-77-13-12 / e-mail felekeam@yahoo.com

3. Ato Telake Azale (BSC,MPH): University of Gondar
   Mobile;+251-19-18-77-19-51 / e-mail telakea@yahoo.com

የጥናቱ ርእስ

ኤች አይቪ /ኤድስን / ለመከላከል የሚረዱ በእዉቀት ፣በአመለካከት፣ በተግባር ያሉትን ትልቅ ልዩነቶች መንስኤውን አውቀን ችግሩን ለማሻሻልና የባህሪ ለውጥ ለማምጣትእንቅፋት የሆኑ ነገሮችን መለየት

ጥናቱን የሚያጠናው አረጋሽ ሞላ

አማካሪዎች አቶ አምሳሉ ፈለቀ

አቶ ተላከ አዛለ

የድርጅቱ ስም -ጎንደር ዩኒቨርስቲ የህክምናና ጤና ሣይንስ ኮሌጅ የህብረተሰብ ጤና

ትምህርት ክፍል

ለጥናቱ ገንዘብ የሚያወጣው ድርጅት -በግል

ይህ ስለጥናቱ የማስተዋዋቅያ ወረቀት የተዘጋጀውኤች አይቪ /ኤድስን / ለመከላከል የሚረዱበእዉቀት ፣በአመለካከት፣ በተግባር ያሉትን ትልቅ ልዩነቶች መንስኤውን አውቀን ችግሩን ለማሻሻልና የባህሪ ለውጥ ለማምጣትእንቅፋት የሆኑ ነገሮችን መለየት ሲሆን ጥናቱም በጎንደር ከተማ ነዋሪ በሆኑ የማህበረሰብ ክፍሎች ላይ ይካሄዳል፡፡

መግቢያ

ይህ ስለጥናቱ የሚገልጽ ወረቀት የተዘጋጀው የጥናቱን አላማ በመግለጽ መሰረት ያደረገና በጥናቱ ለመሳተፍ ፍላጎት ያለው ማንም ሰው መሳተፍ ይችላል የጥናቱ ዋና ዓላማኤች አይቪ /ኤድስን / ለመከላከል የሚረዱበእዉቀት ፣በአመለካከት፣ በተግባር ያሉትን ትልቅ ልዩነቶች መንስኤውን አውቀን ችግሩን ለማሻሻል ና የባህሪ ለውጥ ለማምጣትእንቅፋት የሆኑ ነገሮችን መዳሰስና ለዚህም የተለያዩ ተያያዥጉዳዮችን ማየት ይሆናል፡፡

በዚህ ጥናት ላይ የሰለጠኑ 10 የመረጃ አሰባሳቢ የማህበረሰብ አማካሪዎች፣ 2 ቢ ኢስ ሲ ነርሶች መረጃ ሰብሳቢዎችን የሚቆጣጠሩ ፣ 1ዋና ተመራማሪ እና ከጎንደር ዩኒቨርስቲ 2 አማካሪዎችን ይይዛል፡፡

ይህ የኢንፎርሜሽን ሽትና የስምምነት ማረጋገጫ የተዘጋጀው ስለሚካሄደው ጥናት ግንዛቤ ኑሮዎት የበኩሎዎትን አስተዋጽኦ እንዲያደርጉ ነው፡፡

ጥናቱ የሚካሄደው በአማራ ብሔራዊ ክልላዊ መንግስት በሰሜን **ጎንደር ዞን** በጎንደር ከተማ ቤት ለቤት በመዞር **ሲሆን የጥናቱ ዋና ዓላማ** ዓላማኤች አይቪ /ኤድስን / ለመከላከል የሚረዱበእዉቀት ፣በአመለካከት፣ በተግባር ያሉትን ትልቅ ልዩነቶች መንስኤውን አውቀን ችግሩን ለማሻሻል እና የባህሪ ለውጥ ለማምጣትእንቅፋት የሆኑ ነገሮችን መዳሰስና ለዚህም የተለያዩ ተያያዥጉዳዮችን ማየት ይሆናል ፡፡

ማብራሪያው የተዘጋጀው በጎንደር ዩኒቨርስቲ የሕብረተሰብ ጤና ሳይንስ ትምህርት ክፍል 2ኛ ዓመት የድህረ ምረቃ ተማሪና በጎንደር ዩኒቨርስቲ አማካኝነት ነው፡፡

1. የ<u>ጥናቱ ዓላማ፡</u>

በሰሜን ጎንደር ዞን በጎንደር ከተማ ቤት ለቤት በመዞር የህብረተሰቡን ኤች አይቪ /ኤድስን / ለመከላከል የሚረዱ ባህሪያትን ለመለየትና የባህሪ ለውጥ ለማምጣት እንቅፋት የሆኑ ነገሮችን ለመዳሰስ ና የባህሪ ለውጥ ለማምጣትና **ማነቆ የሆኑ** ጉዳዮችን ና ተያያዥ ችግሮችን ለመለየትና በእዉቀት ፣በአመለካከት፣ በተግባር ያሉትን ትልቅ ልዩነቶች መንስኤውን አውቀን ችግሩን ለማሻሻል አናከእናት ወደ ልጅ አንዳይተላለፍ ለመከላከል ና ትውልድን ለማዳን ኤችአይቪ ለመከላከል ማነቆ የሆኑ ጉዳዮች ላይ መስራት አለብን።ይህ ጥናት መንግስታዊ ና መንግስታዊ ያላሆኑ ድርጅቶች በተለይ ኤችአይቪ ኤድስ ለመከላከል ለሚሰሩ ድርጅቶች ጥሩ የጥናት መሰረት ሆኖ ያገለግላል።እንዲሁም ጥሩ የሆነ የምክክር አገልግሎት ለመስጠት ያስችላል።ወሳኝ ምክንያቶች በጥናት ለማወቅና ለወደፊቱ ፕሮግራሙን የተሻለ ለማድረግ ነው።

2. <u>የጥናቱ ሂደት</u>

ጥናቱ የሚካሄደው ኳንቲታቲቭ እና ኳሊቴቲፍ የሚባሉትን ዘዴ በመጠቀም በጎንደር ከተማ የሚገኙ እድሜያቸው ከ15-49የሆኑ ወንዶችም ሴቶችም በተዘጋጀው መጠይቅ መሠረት ጠይቆ ፎርሙን በመሙላትእና ከፎርሙ ውጭም አንድ ስድስት ጥያቄዎችን ሲሆን ጥናቱን ለማካሄድ ፈቃድ ከጎንደር ዩኒቨርስቲ፣ ከዞን ጤና መምሪያና ከወረዳ ጤና ጥበቃ ጽ/ቤት ፈቃድ ሲገኝ ይሆናል።

3. <u>ሊከሰቱ የሚችሉ ስጋቶችና የምጆት መጓደሎች፡-</u>

በዚህ ጥናት በመሳተፈዎ ምን አልባት ጊዜዎን ሊሻማበዎት ይችል ይሆናል ከዚያ ውጭ ሌላ ምንም ችግር አያመጣም ወይም አያጋጥመዎትም ምክንያቱም ማንኛውም ኢንፎርሜሽኑን የሚያዘው በሚስጥር ስለሆነ ነው።የእርስዎ መልስ ለእኛ እንደ ተልቅ ግብአት ያገለግለናል።ያለውን ክፍተት ለማየትና ማነቆ ለሆኑ ጉዳዮችለማማሻሻል ይጠቅመናል።

4. <u>ጥቅሞች፡-</u>

ጥናቱ በሚካሄድበት አካባቢ ለሚገኙ ጤና ድርጅቶች፣ ጤ/ጥ/ጽ/ቤትና ሌሎችም በጥናቱ ስለሚሳተፉና በውጤቱ መሠረት ለፕሮግራሙ ማነቆ የሆኑ ችግሮችን ለይቶ ለማወቅና መፍትሄ ለማፈላለግ ትልቅ አስተዋጽኦ አለው።

ርስዎ በዚህ ጥናት በመሳተፍዎ የተለየ ጥቅም አያገኙም ነገር ግን የርስዎ በጥናቱ መሳተፍ ለእኛ የባህሪ ለውጥ ለማምጣትና **ማነቆ የሆኑ** ጉዳዮችንና ተያያዥ ችግሮችን ለመለየትና በእዉቀት ፣በአመለካከት፣ በተግባር ያሉትን ትልቅ ልዩነቶች መንስኤውን አውቀን ችግሩን ለማሻሻል እንዲሁም ጥሩ የሆነ የምክክር አገልግሎት ለመስጠት ያስችላል።

5.ማካካሻ፡-

በዚህ ጥናት በመሳተፈዎ ምንም አይነት ማካካሻ አይሰጠዎትም ነገር ግን በጥናቱ በመሳተፈዎ ምስጋናችን ከፍ ያለ ነው፡፡

6. ሚስጥር መጠበቅ፡-

የሚጠየቁት የሰዎች **ስም አይመዘገብም** በሽተኛው ተጠይቆ የሚመልሳቸው **መልሶች ብቻ ይመዘገባሉ፡፡ ይህ የተመዘገበው መረጃም ሚስጥራዊ ስለሆነ** ከዋናው ተመራማሪና ከረዳት ተመራማሪው ውጭ ለማንም አይገለጽም፡፡ በጥናቱ ያለመሳተፍ ወይም ራሰዎን ከጥናቱ የማግለል መብተዎ በማንኛውም ጊዜ የተጠበቀ ነው፡፡

7.መረጃ ስለማግኘት

ይህ የጥናት ፕሮጀክት በጎንደር ዩኒቨርስቲ የቅድመ ምርምር ኮማቴ (Ethical committee) ታይቶ እንዲፀድቅ ይደረጋል፡፡ **ማንኛውም አይነት ጥያቄ ካለዎት** አረጋሽ ሞላን ፊት **ለፊት ወይም በስልክ ቁጥር *09 18 72 38 58* በማንኛውም ጊዜ ማነጋገር ይችላሉ፡፡ ወይም** አቶ አምሳሉ ፈለቀን በስልክ ቁጥር ***09 18 77 13 12*** ወይም አቶ ተላከ አዛለ በስልክ ቁጥር 09-18-77-19-51 ***ማነጋገር ይችላሉ፡፡***

ከላይ የተዘረዘሩትን ሃሳቦች በደንብ ተገንዝቤ በጥናቱ ለመሳተፍ ተስማምቻለሁ፡፡

ስም_____ፊርማ_____ ቀን _____

ይህ መጠይቅ በአራት ንዑሳን ክፍሎች የተከፈለ ሲሆን 47 ጥያቄዎች አሉት፡፡ ጥያቄዎች ከመጀመራቸው በፊት የስምምነት መግለጫ ይገኛል፡፡ ይህን መጠይቅ ለመረጃ መሰብሰቢያነት ከመጠቀም በፊት ሁሉም ገጾችና ጥያቄዎች መኖራቸውን ያረጋግጡ፡፡ መረጃ ለመሰብሰብ በቅድሚያ የስምምነት መግለጫውን ለመረጃ ሰጪ በጥሞና አንብበው መስማማታቸውን በፊርማ ያረጋግጡ ለእያንዳንዱ ጥያቄ መረጃ ሰጪ የሚሰጡትን መልስ በመልስ እረድፍና በጥያቄው አካያ የሚገኘውን ቁጥር ያክብቡ በእያንዳንዱ ክፍለ ጊዜ መጠይቅ ሲጀምሩ እና ሲያጠናቅቁ ሰዓቱን ይፃፉ፡፡ሲጨርሱ አሚልተው መመዝገብን በማረጋገጥ ይፈርሙ

የስምምነት መግለጫ፡-

ስሜ ---------- ----------ይባለል፡፡ የጎንደር ዩኒቨርስቲ የ/ጤ/ሳይንስ ትም/ት ክፍል በሚካሄደው ጥናት ውስጥ በጊዜያዊ መረጃ ሰብሳቢነት በመስራት ላይ እገኛለሁ፡፡ የጥናቱ አላማም ኤች አይቪ /ኤድስን / ለመከላከል የሚረዱ ባህሪያትን ለመለየትና የባህሪ ለውጥ ለማምጣትእንቅፋት የሆኑ ነገሮችን ለመዳሰስ በእዉቀት ፣በአመለካከት፣ በተግባር ያሉትን ትልቅ ልዩነቶች መንስኤውን አውቀን ችግሩን ለማሻሻል በጥናቱ በርካታ ህብረተሰብ ማሳተፍ አስፈላጊ በመሆኑ በተለያዩ ቦታዎች የመረጃ ስብሰባው በመከናወን ላይ ነው፡፡

በዚህ ጥናት ስለ ግል ህይወት፣ስለ ቤተሰብ፣ስለ አካባቢ፣ ስለ ኤች አይ ቪ እና የመሳሰሉት ጉዳዮች ይጠየቃሉ፡፡ አንዳንድ ጊዜ ለራስ የማይመች ጥያቄ ሊጠየቁ ይችላሉ፡፡ የእርሰዎን ማንነት የሚያመለክት መረጃ ፈፅሞ አይመዘገብም፡፡ የሚሰበሰበው መረጃ ተጠቃሎ በዋናው አጥኝ በጥንቃቄ የሚቀመጥ ሲሆን ጥናቱ ሲጠናቀቅ ማንም ሰው በማያገኘው ሁኔታ ይወገዳል፡፡ መጠይቁ የሚካሄደው በፍፁም ፈቃድ ነው፡፡ከዚህ ጥናት የሚገኘው ውጤት ለወደፊቱ ፕሮግራሙን የተሻለ ለማድረግ ይጠቅማል፡፡ በአጠቃላይ መጠይቁ ከ25-30 ደቂቃ ይወስዳል፡፡ በትዕግስትና በጥሞና አዳምጠው ለመመለስ የሚያደርጉትን ጥረት እያደነቅን በቅድሚያ ከልብ እናመሰግናለን፡፡በጥናቱ ለመሳተፍ ፈቃደኛ ነዎት? ካልሆኑ አመስግነሽ/አመስግነህ አሰናብት፡፡ ፈቃደኛ ከሆኑቀጥይ/ቀጥል/፡፡

ፈቃደኝነታቸውን ያረጋገጠችው/ ያረጋገጠችው/ ጠያቂ ስም ----------ፊርማ ----------

Declaration

I, the undersigned, senior MPH student declare that this thesis is my original work in partial fulfillment of the requirement for the degree of Master of Public Health.

Name: _____

Signature: _____

Place of submission: School of Public Health, College of medicine and Health Sciences, University of Gondar.

Date of Submission: _____

This thesis work has been submitted for examination with my/our approval as university advisor(s).

Advisors

Name	**Signature**
_____	_____
_____	_____

ASSURANCE OF INVESTIGATOR

The undersigned agrees to accept responsibility for the scientific, ethical and technical conduct of the research project and for provision or required progress reports as pre terms and conditions of the research and publications office of the Univesity of Gondar.

Name of the student: Aregash Molla

Date: _____ Signature _____

Approval of the Advisor(s)

	Name	**Signature**	**Date**
1.	Mr. Amsalu Feleke (Associate proff.)	_____	_____
2.	Mr. Telake Azale(BSC, MPH)	_____	_____